

Manual for Durable Medical Equipment, Orthotics, Prosthetics & Supplies (DMEOPS)



Published by:
Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505

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FORWARD

PURPOSE

This handbook has been prepared for the information and guidance of durable medical equipment and medical supply providers who provide items or services to participants in the Department's Medical Programs. Contained in this handbook are both policy and procedures for durable medical equipment and medical supply items and services. This handbook provides information on which items require prior approval and how to obtain prior approval.

Providers will be held responsible for compliance with all policy and procedures contained herein.

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KEY CONTACTS

THIRD PARTY LIABILITY:

For questions about private insurance, Medicare, or other third-party liability:

(800) 755-2604
(701) 328-3507

Send written inquiries to:

Third Party Liability Unit
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

ELECTRONIC CLAIMS:

For questions regarding electronic claims submission:

(800) 755-2604
(701) 328-2325

Fax: 1-(701) 328-1544

PAPER CLAIMS:

Send paper claims to:

Claims Processing
Medical Services
ND Dept of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

PROVIDER RELATIONS:

For questions about recipient liability payments, denials or general claims questions:

(800) 755-2604
(701) 328-4030

PRIOR AUTHORIZATION (PA):

Mail or fax all requests for prior authorization to:

Medical Services
Administrator Quality Care/Disability
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Fax: 1-(701) 328-0370

PROVIDER INFORMATION:

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider.html>

STATEMENT OF INTENTION

Supersedes: North Dakota Medicaid DMEOPS (Durable Medical Equipment, Orthotics & Prosthetics, and Medical Supplies) Manual, March 2003, and all changes that have occurred in memorandums.

References: Title XIX, Social Security Act; United States Code (USC) §§ 1396-1396v, Subchapter XIX, Chapter 7, Title 42; Code of Federal Regulations (CFR), Chapter IV, Title 42, Subtitle A, Title 45; Administrative Rules of North Dakota Title 37.75, Chapter 02

Updated: June 2006

Codes, References, Etc. Mentioned in This Manual are Excepts From:

- American Medical Association Current Procedural Terminology (CPT) 2006
- CMS Healthcare Common Procedure Coding System (HCPCS) 2006
- References are available at local bookstores or <http://www.ingenixonline.com/expert>

PURPOSE OF THE MEDICAID PROGRAM

The North Dakota Legislature enacted legislation, which permits direct payment to providers for medically necessary services, provided to medical assistance recipients. This legislation is contained in Title 75 Article 02, Chapter 02 of the North Dakota Administrative Code. This law conforms to Title XIX of the Federal Social Security Act, Section 1901, to enable each state to furnish:

- Medical assistance on behalf of families with dependent children, aged, blind or disabled individuals, whose income and resources are insufficient to meet the cost of necessary medical services; and
- Rehabilitation and other services to help such families and individuals to attain or retain the capability of independence or self-care.

This program is referred to as Medicaid, or Title XIX. Funding is provided by a combination of state and federal dollars.

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES DIVISION

Department of Human Services is the designated State Agency that administers the Medicaid or Title XIX Program. The Department's legal authority is contained in Title 75, Article 02, Chapter 02 of the ND Administrative Code. At the federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

The Medicaid Program is administered in accordance with the Administrative Rules of North Dakota, Title 75. These rules are developed within the authority granted under the state and federal statutes and federal regulations cited above.

INTRODUCTION

Thank you for your willingness to serve the clients of the North Dakota Medicaid program and other medical assistance programs administered by the Department of Human Services

MANUAL ORGANIZATION

- This manual provides information specifically for providers of Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies (DMEOPS).
- Other essential manuals are the [General Information For Providers](#), and other Medical Assistance program manuals.
- Each provider is asked to review both the general manual and the specific manual for their provider type.
- Manuals can be found on the Medicaid website <http://www.nd.gov/humanservices/services/medicalserv/medicaid/> select Medicaid Provider Information, and accept the “End User Agreement for Providers.”

RESPONSIBILITY FOR INFORMATION

All approved updates and changes to the DMEOPS provider manual will be made available on the Department’s website via the [Update Providers Link](#).

- This manual and notices are provided only as guides and do not lessen the responsibility of the provider to know and follow current laws and regulations
- Providers must replace all applicable page(s), inserts, and bulletins to maintain a current provider manual
- This manual should be made available to billing personnel
- This manual should be used as a reference source for questions regarding coverage, billing, as well as covered and non-covered items

PROVIDER ENROLLMENT

To become a North Dakota Medicaid Durable Medical Equipment and Supply Provider, Medical Services must approve a provider’s completed and signed enrollment application form. When signed by the provider and approved by Medical Services, the enrollment form becomes a contractual agreement between Medical Services and the provider. See Appendix A – [Provider Enrollment Forms](#).

Medicaid payments will be made only to enrolled providers. Enrollment forms, when completed, are mailed to:

- Provider Enrollment
Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

They are also available on our [“Provider Enrollment”](#) website.

Providers must notify Provider Enrollment in writing when there is a change of address or ownership. Written notification must be sent to:

- Provider Enrollment
Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

Providers and their employees shall abide by all applicable rules:

- Of the Department of Human Services
- Of State and Federal laws and regulations governing the Medicaid program
- Standards and ethics of their own business and profession

Providers must be familiar with all current rules and regulations governing the North Dakota Medicaid program:

- Provider manuals are to assist providers.
- The manuals do not contain all the Medicaid rules and regulations. They are citations and may not be a complete summary of the entire rule.
- In the event that a manual conflicts with a rule, the rule prevails.

Providers shall not discriminate in the provision of service to eligible Medicaid recipients on the grounds of race, creed, color, sex, national origin, or handicap. Providers shall comply with all requirements imposed by or pursuant to the regulation of:

- Medicaid regulations under Title VI and Title IX of the Civil Rights Act
- Public Law 92-112 (Section 504 and 505)
- North Dakota Human Rights Act, Title 49, Chapter 2
- Americans with Disabilities Act

We encourage providers to enroll for electronic submission of claims.

Electronic claims submission:

- Provides a standardized format
- Guarantees uniformity helping to reduce the chance of error in data exchange and processing
- Allows submitters to exchange electronic data with multiple entities while using the same format structure
- Reduces administrative costs for paper and postage

CHANGES IN ENROLLMENT

A new provider enrollment must be completed for changes in:

- Ownership
- IRS reporting number
- Legal status

Changes in address, telephone number, or licensure can be submitted in writing or via fax and do not necessitate a new provider enrollment. Any name changes without change to IRS reporting number will require the submission of a new W-9 form.

CHANGE IN OWNERSHIP

- The new owner must apply for a new North Dakota Medicaid number.
- Providers must notify [Provider Enrollment](#) at least 30 days in advance of any changes that cause a change in the tax identification number.
- Early notification helps avoid payment delays and claim denials.

TERMINATING MEDICAID ENROLLMENT

Medicaid enrollment may be terminated at any time by writing to the [Provider Enrollment](#) Unit. Include your provider number and the termination date in the letter. North Dakota Medicaid may also terminate your enrollment under the following circumstances:

- Breaches of the provider agreement.
- Demonstrated inability to perform under the terms of the provider agreement.
- Failure to abide by applicable North Dakota and U.S. laws.
- Failure to abide by the rules and policies of the North Dakota Department of Human Services or the North Dakota Medicaid program.

PROVIDER REQUIREMENTS

By signing the application to enroll in North Dakota Medicaid, providers agree to abide by the conditions of participation addressed on the provider agreement. This form is available at <http://www.state.nd.us/eforms>. This section includes:

- No client should be abandoned in a way that would violate professional ethics.
- Clients may not be refused service because of race, color, national origin, age, or disability.
- If a client is eligible for Medicaid, and the provider does not want to accept Medicaid payment for service or item requested, the client **MUST** be informed in advance of providing the service.

- When a provider arranges ancillary services for their Medicaid client through other providers the ancillary providers are considered to have accepted the client as a Medicaid client and they may not bill the client directly unless a service had been denied as non-covered.
- Most providers may begin Medicaid coverage for retroactively eligible clients at the current date or from the date retroactive eligibility was effective.
- When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.

PAYMENT FOR SERVICES

Providers are entitled to Medicaid payment when the following conditions are met:

- Provider must be enrolled in Medicaid.
- Services must be ordered by a Physician operating within the scope of their practice as defined by law.
- Client must be enrolled in Medicaid and non-restricted.
- Service must be medically necessary. North Dakota Medicaid may review medical necessity at any time before or after payment.
- Service must be covered by Medicaid and not be considered experimental or investigational.
- Medicaid and/or third party payers must be billed according to rules and instructions described in the *Billing Procedures* chapter of the [General Information for Providers](#) manual, the most current [Medicaid Bulletin](#) and any inserts or updates posted via the Department website.
- Billed charges must be usual and customary.

Note: No separate additional charge is to be made for freight, postage, delivery, installation, set-up, instruction, fitting, adjustment, measurement, facility visits or transportation, since these services are considered to be all-inclusive in a providers charge.

MEDICAID PAYMENT IS PAYMENT IN FULL

Providers must accept Medicaid payment as payment in full for any covered service, except applicable co-payments or recipient liability that should be charged to the client.

UTILIZATION MANAGEMENT

- The [Utilization Team](#) reserves the right to deny any prior/claim for equipment and supplies at any time during the prior/claims review process if the request does not meet the requirements for coverage.

- An allowance can be reverted by the [Utilization Team](#), if that allowance was made in error.

CLAIMS REVIEW

The Department is committed to paying Medicaid provider's claims as quickly as possible.

- Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed.
- Although the computerized system can detect and deny most erroneous claims, there may be some erroneous claims, which it may not detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct.
- Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment.

If a claim is paid and the Department later discovers that the services were incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by the federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of the Department, provider error or other cause. Refer to section: [What Is The Function Of SURS](#).

GETTING QUESTIONS ANSWERED

- The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as [Provider Relations](#)).
- The list of [Key Contacts](#) at the front of this manual has important numbers and addresses pertaining to this manual.
- The [General Information For Providers](#) manual also has a list of contacts for specific program policy information.
- Medicaid manuals, notices, inserts, updates, fee schedules, forms, and much more are available on the [Provider Information](#) website (see [Key Contacts](#)).

GENERAL COVERAGE PRINCIPLES

This chapter provides covered service information that applies specifically to services and supplies provided by Durable Medical Equipment, Orthotic, Prosthetic, and Medical Supply (DMEOPS) providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *Provider Requirements* chapter of the [General Information For Providers](#) manual.

DRAFT

North Dakota Medicaid follows Medicare's coverage requirements for some items. A Medicare manual is available from the Durable Medical Equipment Regional Carrier (DMERC) website. North Dakota Medicaid considers Medicare, Region D, DMERC medical review policies as the minimum DMEOPS industry standard. This manual covers criteria for items, which are either in addition to Medicare requirements or are items Medicare does not cover.

North Dakota Medicaid coverage determinations are a combination of Medicare, Region D DMERC policies; Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions and Department designated medical review decisions. DMEOPS providers are required to follow specific North Dakota Medicaid policy or applicable Medicare policy when North Dakota Medicaid policy does not exist.

SERVICES FOR CHILDREN

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients under age 21.

- EPSDT is designed to prevent, identify, and then treat health problems before they become disabling.
- Children with needs identified during a screening may receive any medically necessary DMEOPS item/items described in this manual.
- All applicable prior authorization requirements apply.

PROVISION OF SERVICES

Federal regulations require that items covered by the Department be:

- Reasonable and necessary in amount, duration and scope to achieve their purpose.
- The most economical and efficacious available to fulfill the basic medical need.
- Ordered by a physician.
- DME and supplies are covered only for recipients who reside at home. Home may be a house, apartment, relative's home, or a group facility. Institutions such as, hospitals, nursing facilities, swing beds and ICF/MR facilities would not be considered a home. Some exceptions apply. See [Appendix D](#).

Recipients in institutions who plan to return to their own homes may receive consideration for equipment received prior to discharge if the equipment will be used in the recipient's home. Recipient's wishes, preferences and personal conveniences are not medical needs.

PROVIDER DOCUMENTATION

- North Dakota Medicaid will only accept physician signatures on prior authorization requests.
- The recipient must have been examined within the past 60 days and the physician must provide sufficient clinical rationale to substantiate the medical need of the ordered equipment or supplies.

DRAFT

- Recipient's history and current medical condition must be carefully considered before any prescription for equipment or supplies is written. The client's medical record must contain sufficient documentation, proof of delivery and original prescriptions and all must be made available upon request of the Department. The client's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home-health agency records or records from other professionals.
- The diagnosis, medical necessity, and the projected length of need for a covered item must be included on the prescription, prior auth, or Certificate of Medical Necessity (CMN).
- In the absence of proper and complete records, no payment will be made and payments previously made will be recouped.
- Medical supplies used on a continuous basis must be renewed by a physician at least every 12 months and must specify the monthly quantity.
- Prescriptions for oxygen must include the liter flow per minute, hours of use per day and the client's PO2 or oxygen saturation blood test results (CMN required)
- Medicaid will cover maintenance, labor, repairs and replacement to recipient owned equipment of covered items that are medically necessary.
- If an accepted CMN form has a physician's signature and date, a signature is not required on the Prior Authorization Request (PAR) form

CERTIFICATE OF MEDICAL NECESSITY

For a number of DMEOPS items, a CMN is required to provide supporting documentation of the client's medical needs. The CMN must be signed and dated by the physician.

- Failure to obtain a properly completed CMN is cause for non-payment.
- Periodically, a CMN may be added to this list and providers will be notified via the Departments website under the [Update Provider Link](http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider):
[Http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider](http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider)

The following is a list of items that require a CMN along with the corresponding form number. To obtain the form click on the form number: *(Not all links are available at this time)*

– Apnea Monitors	SFN #
– Chest Wall Oscillating Device	SFN #
– CPAP/BiPAP	SFN #
– Enteral Nutrition	SFN #782
– External Infusion Pump	SFN #780
– Hospital Beds	SFN #785
– Manual Wheelchairs	SFN #781
– Motorized Wheelchairs	SFN #720
– Osteogenic Bone Stimulators	SFN #722
– Oxygen Equipment	SFN #729
– Parenteral Nutrition	SFN #726
– Respiratory Assist Devices (BiPAP)	SFN #
– Seat Lift Mechanism	SFN #724

- Section C Continuation Form..... SFN #727
- Speech Generating Device..... SFN #
- Support Surfaces (Pressure Reducing) SFN #728
- Transcutaneous Electrical Nerve Stimulator (TENS)..... SFN #789

RENTAL/PURCHASE

- All rental items need to have prior approval.
- North Dakota Medicaid will purchase equipment when it is expected to be cost-effective.
- After the 12-month rental period, the Medicaid recipient will be deemed to own the item and the supplier must transfer ownership of the item to the client. The supplier providing the item in the specified rental period is responsible to transfer ownership to the client.
- Any Department approved piece of equipment that will be rented by the clients primary payer will also be rented by Medicaid provided the Department has determined medical necessity and the item is covered.
- Maintenance and repair costs for rental equipment will not be covered. Recipients are responsible for caring for equipment.
- Recipient misuse or abuse, of patient owned equipment, resulting in the need for repairs will not be covered by the Department and will be the responsibility of the recipient.
- Providers cannot bill recipients of the Medicaid program for repair, parts, or other equipment or supplies covered by an expressed or implied warranty and the provider must identify the extent of a warranty for any item they supply and inform the recipient of such.
- Rental approved by North Dakota Medicaid are limited to a maximum period of 12 months. All necessary supplies and maintenance needed to operate the rented equipment shall be included in the rental amount. No additional allowances will be paid, except those identified in the guidelines.
- All rentals are paid on a monthly basis (1 unit of service per month). Payment will be made on an entire monthly rental fee for the initial month of rental even if less than a full month. When a rental period extends into a second or subsequent month, payment will be allowed for a partial month only if the partial month period is at least 15 days.
- A change in supplier during the 12-month period will not result in the start of a new 12-month period.
- Suppliers are responsible to investigate whether another supplier has been providing the item to the individual. Medicaid will not supply this information.
- Only interruptions in the rental period of 90 days or greater will result in a new 12-month rental period and will require a new prior authorization.
- Covered equipment may be rented or purchased at the discretion of the department.

All necessary supplies, maintenance, repair, components, adjustments, and services needed to operate the rental equipment are included in the rental amount. No additional allowances will be paid except those identified in the guidelines.

REPAIRS

Repairs must receive prior approval and are covered when they:

- Are necessary to make the items useful,
- Have been ordered by a physician, and
- Do not total more than 75% of replacement cost.

Payment will not be made for repairs to equipment used in a skilled nursing facility, ICF/MR or a swing bed, unless that equipment was patient owned before entering such facility.

Repair charges are to be billed under the appropriate HCPC code for the item to be repaired along with the RP modifier. An itemized breakdown of the repair charges must be attached to the prior.

NON COVERED EQUIPMENT AND SUPPLIES

Reimbursement is limited to only the most economical and medically necessary DME delivered in the most appropriate and cost effective manner. An item is not reimbursable if there is another item that is equally safe, effective, and substantially less costly.

The following are items and/or categories of items that are non-covered/ no exception through the DMEOPS program. All coverage decisions are based on federal and state mandates for program funding by the U.S. Department of Health and Human Services, including the Medicare Program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Exercise/therapeutic items
- Educational items
- Items/services provided to a client in a skilled nursing facility setting

The easiest way to verify coverage of a specific item is to check the Department's fee schedule via the [Providers Website](#). In addition to being listed on the fee schedule, all items provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the [General Information For Providers](#) manual, and meet all requirements listed in the DME guidelines found later in this manual. Maximum rates, quantity limitation and need for prior approval for each item is also listed.

Generally, DME is not useful to a person in the absence of illness or injury. The item must be appropriate for use in the home or residence. Items that are beneficial primarily in allowing leisure, recreation, or daily living activities are not reimbursable. Medicaid has no liability for such services, supplies, or equipment. See [Appendix C](#), [Appendix D](#), or for a list of non-covered items and items that may or may not be allowed when a client is in a ICF/MR, skilled nursing facility, or swing bed facility. This list may not be all-inclusive.

PRIOR AUTHORIZATION

Other than those specifically defined as “[Always Requiring Prior Approval](#),” prior authorization is required for all items costing \$500 or more, supplies costing \$500 or more per month, estimated annual accumulative rental or supplies of \$500 or more, miscellaneous charges, and all labor or repair charges. Providers must submit for prior authorization by fulfilling all requirements (see [Prior Authorization Form Completion Guide](#)).

To ensure federal funding requirements are met, certain items are reviewed before delivery to a Medicaid client. These items are reviewed for appropriateness based on the client's medical need. In determining medical appropriateness of an item, the Department Utilization Review Staff applies six criteria when granting prior approval. The equipment must:

- Be medically necessity;
- Be appropriate and effective to the medical needs of the recipients;
- Be timely, considering the nature and present state of the recipients medical condition;
- Be furnished by a provider with appropriate credentials;
- Be the least expensive appropriate alternative health service available; and
- Represent an effective and appropriate use of program funds.

Note: Prior approval to provide services does not include any determination of the client's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient eligibility on the date of service.

If an item is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item to the client. Prior authorization is required for dispensing units over the

maximum allowed and supporting documentation must accompany. Supporting documentation must be physician driven. When requesting prior authorization, remember:

- Only Medicaid enrolled DMEOPS providers may request PA.
- Clients must be eligible for Medicaid.
- Submit a completed [Prior Authorization Request Form](#) (SFN 1115)
- Include appropriate supporting documentation.
- Documentation must be complete, including appropriate signatures and dates.
- Documentation must support medical necessity.
- Use the appropriate place of service.
- Use current correct coding.
- Use the correct CMN for that item (if required).
- Fax or mail the request and supporting documentation to Medical Services (see [Key Contacts](#)).
- Upon completion of the review, a prior approval notification will be mailed to the client and the requesting provider. Upon receipt of the prior approval notification, the item(s) may be billed. The claim must contain the prior approval number and match the prior approval exactly.
- Patients are entitled to choice of providers and may choose to change providers for rental items or ongoing supply needs. The prior will not automatically transfer to a new provider. Either the new or old provider must contact the Department to transfer to the new provider. The Department may request verification that the patient chose to make the change.

The Department cannot and will not allow a prior authorization request solely for denial in order to receive payment from another source. Instead, provide the alternative payer with documentation supporting the non-coverage of the item (Provider manuals, Department notices and/or bulletins or requested documentation from [Provider Relations](#) will assist you in this process).

PRIOR AUTHORIZATION FORM COMPLETION GUIDE

All information on the Prior Authorization Form (click on link to the right to access form) must be legible and complete or the form will be returned for clarification. Type or hand-write clearly with blue or black ink.



PRIOR AUTHORIZATION REQUEST
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1115 (Rev. 05-2003)

Patient Information:

1. Patient's name, date of birth, and ID number are required. Enter as name and number appear on the North Dakota Medicaid identification card.
2. Patient's address is required. Enter street and city.
3. Patients' residence is required (must use most current residence). Enter type of living arrangement.

Part I. To be completed by the physician.

1. Item prescribed is required. Can be completed by the supplier or physician.
2. Diagnosis and prognosis are required. Can be completed by the physician or physician's staff. ICD-9 codes with the description must also be entered.
3. Explanation of medical necessity and duration of need are required. Must be completed by the physician. Be as brief as possible without omitting information, which will support the medical necessity of the item requested.
4. Physician's name is required. Can be completed by the physician or physician's staff.
5. Provider number is required. If required to use an NPI number, please enter that number
6. Physician's signature is required. Must be signed by the physician or a signed/dated prescription attached to the prior.
7. Date is required. This is the date the form/prescription is signed by the physician.

Part II. To be completed by the provider (supplier)

1. Provider's name is required. The name of the DME supplier or pharmacy
2. Provider's number is required. The North Dakota Medicaid provider number assigned by this department.
3. Telephone number is required. The telephone number of the DME supplier or pharmacy actually providing the DME supplies, services, or drugs.
4. Providers' street address, city, state, and zip are required. The address of the DME supplier or pharmacy actually providing the DME supplies, services or drugs.
5. Provider signature is required. The signature of the person authorized by the provider to complete the prior approval form.
6. Date is required. The date the provider completes the prior approval form.
7. NDC/HCPC codes are required. This must match billing codes or the claim will reject. Remember to include the appropriate modifier for rental, purchases, repairs, etc. Miscellaneous codes can be used only if there is no other appropriate code available. For items identified by the same code, list the code once and combine those items and costs on the same line after that code.
8. List is required. The item, make/model, units, day's supply, quantity per case, hours/minutes of repair time/labor/evaluation. Comment: any additional information pertinent to the description of the products/services.
9. Date of service/Start and stop date is required. The estimated or actual date the item is provided to the recipient.
10. Customary or usual retail is required. The price charged the general public for purchase or rental of the product or service to be provided.
11. Acquisition cost. The acquisition cost to the supplier.
12. Number of units is required. The number of units to be provided under the authorization of this prior approval.

Suppliers are responsible for retaining copies of supporting documentation of products, services, and medical necessity and make this information available upon request by the department.

To be eligible for post approval consideration, all the normal requirements for prior approval must be met, and the Department must receive the post approval requests no later than 90 days from the date the services or items were provided.

QUANTITY LIMITATIONS:

Whether prior approval is required or not, the quantity of medical supplies will be limited to the amount indicated by the ordering physician or to a reasonable quantity for a month, whichever is less. For many items, the Department has established maximum allowable quantity limits that may be dispensed within a given time period. Quantities up to these maximums may be dispensed without prior approval, if all other requirements in this handbook have been met. (See [Prior Authorization](#)) Quantities over the designated maximums require prior approval.

If the attending physician has ordered a quantity that exceeds the designated maximums, the supplying provider must behave as if the higher quantity is medically necessary and must attempt to obtain prior approval for the entire order. It is not permissible for the supplying provider to dispense only the Department's maximum allowable quantity, or to dispense the full quantity and bill the patient for the items in excess of the Department's maximum allowable quantity, unless:

- The ordering physician confirms that the excess quantity is not medically necessary, or
- The Department denies the request for prior approval because the excess quantity is not medically necessary.

Only in instances where the supplying provider can clearly document that items are being dispensed solely for patient convenience can the patient be charged. In such instances, the provider must inform the patient of his or her financial liability before dispensing the items.

Note: Providers must contact the patient prior to dispensing each item to ensure the patient continues to want the same provider to serve his or her medical supply needs and that the patient continues to need the items. The patient's medical eligibility must also be verified prior to dispensing.

PRESCRIPTION REQUIREMENTS:

The prescription must indicate:

- Date the prescription is written
- Patient name (first and last name)
- Date of Birth or Medicaid ID Number
- Name of the item prescribed
- Quantity of the item/supply ordered
- Directions for use
- Physician signature

Prescriptions for medical supplies used on a continuous basis must be renewed by a physician at least every 12 months and must specify the monthly quantity.

EXCEPTION REQUESTS

There are 2 lists of non-covered services defined in the Medicaid manual. List One is referred to as “Non-covered – No exception”, list Two is “Non-covered.”

Requests for items included in the “Non-covered – No exception” list will be returned to the provider marked non-covered and no denial will be issued.

Items included in the “Non-covered” list may be requested “as an exception.” This request cannot be from a DME provider, therapist, or representative from the DME provider facility. The request must come from the physician.

In request for an exception, the following will be required:

- Completed [Prior Authorization Request](#) (PAR) form;
- Substantial documentation, with care plan from the physician, describing how this item is medically necessary in this unusual, unique, rare situation;
- Documentation must support why a comparable covered piece of equipment would not be suitable; and
- Documentation indicating why other methods or therapies could not be used.

CODING

Standard use of medical coding conventions is required when billing Medicaid. The most current edition of the following manuals should be used:

ICD-9-CM	ICD-9-CM diagnosis and procedure Codes definitions Updated each October	Available through various publishers and bookstores
HCPCS Level II	HCPCS Level II codes and definition Updated each January and throughout The year	Available through various publishers and bookstores or from CMS at www.cms.gov

COORDINATION OF BENEFITS

WHEN CLIENTS HAVE OTHER COVERAGE

Medicaid clients often have coverage through:

- Medicare
- Workforce Safety and Insurance
- Employment-based coverage
- Individually purchased coverage, etc.

Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation.

IDENTIFYING AND VERIFYING ADDITIONAL COVERAGE

In 1986, federal law required state Medicaid Programs to cost avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid. The providers must obtain information about a recipient's health care coverage from the recipient, the recipient's representative, the county social service office, or through the information provided by the Medicaid remittance advice on the Explanation of Benefits.

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (TPL). See the [General Information For Providers](#) manual, *Client Eligibility and Responsibilities* chapter. Providers should use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer. The following is the easiest way to verify eligibility:

- Check the Medicaid Verify or Medifax System to verify eligibility information.
- Obtain an assignment of benefits from the recipient to ensure direct payment for the TPL.
- Follow the instructions for [Client Eligibility](#) found later in this manual.

PRIVATE HEALTH CARE PLANS AND THIRD PARTY PAYERS

Providers and Medicaid eligible recipients are required to follow the third party payer's policies and procedures to maximize the available benefit.

- If the third party payer does not pay anything on the claim because policy and procedures were not followed, Medicaid will not pay the claim.
- Services for which payment has been denied by the primary payer for reasons other than noncompliance may be eligible for Medicaid reimbursement. Explanation of Benefits (EOB's) or other documentation is required before payment is authorized.
- Third party EOB's and other required documents must be provided only on those billings in which the third party has paid less than 60% of the billed charges or when

the recipient is covered by more than one insurance plan and a balance needs to be billed to Medicaid.

- See the [General Information for Providers](#) manual for more detailed information regarding appropriate billing procedures

RECIPIENT COOPERATION WITH TPL BILLING

If a Medicaid recipient is non-cooperative or fails to cooperate with the third party payer, the provider may contact the applicable county social service office or the TPL Unit at North Dakota Medicaid for assistance.

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INSTRUCTIONS TO CHECKING CLIENT ELIGIBILITY

To inquire regarding client eligibility, please follow the Verify Operational Steps listed below:

VERIFY OPERATIONAL STEPS

FOR ALL VOICE RESPONSES

1. Dial (701) 328-2891 or
1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER AND PRESS # (Receive Message)
3. Enter PATIENT ID NUMBER AND PRESS # (Receive Message)
4. Enter DATE OF SERVICE AND PRESS # (Receive Message)
5. Enter "2" if no more inquiries and to end call **OR**
Enter "1" for additional inquiries and repeat step 3 and 4 above

FOR SPEED DIALING

1. Dial (701) 328-2891 or
1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER AND PRESS #,
PATIENT ID NUMBER AND PRESS #,
DATE OF SERVICE AND PRESS # (Receive Message)
3. Enter "2" if no more inquiries and to end call **OR**
Enter "1" for additional inquiries and repeat step 2
above using PATIENT ID AND PRESS # AND
DATE OF SERVICE AND PRESS #

TO REPEAT INFORMATION

1. Enter "*" to repeat current message
2. Enter "1" for eligibility and recipient liability

BILLING PROCEDURES

CLAIM FORMS

All Medicaid claims must be submitted on Department approved claim forms. The following is an approved form for DME claims: (CMS/HCFA-1500)

Services can be billed electronically or on the CMS/HCFA-1500 claim form. Claims must contain services for only one calendar month because of Recipient Liability (RL) or client eligibility.

Reminder: All supplies are included with rental equipment unless specified otherwise in the guidelines. All supplies for rental equipment **must** be submitted on paper claim. The provider must identify when the equipment is patient owned equipment in box 32 of the CMS/HCFA-1500. The supplies will be denied as included in rental if this identification does not take place.

ELECTRONIC CLAIMS

Electronic Data Interchange (EDI) submission is a fast and cost effective alternative to paper claim submission. Providers can use EDI to submit original claims and resubmit denied claims.

While some providers continue to submit claims on traditional paper forms, more are taking advantage of EDI submission.

PAPER CLAIMS

Unless otherwise stated, all paper claims should be mailed to:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck, ND 58505-0250

Please follow these guidelines. This will help ensure that your claims can be scanned and processed in a timely manner. If claims and attachments are not submitted according to these guidelines, they will be returned to the provider.

North Dakota Department of Human Services
Medical Services
Guidelines for Submission of Paper Claims

May 2006

Please follow these guidelines. This will help ensure that your claims can be scanned and processed in a timely manner. If claims and attachments are not submitted according to these guidelines, they will be returned to the provider.

1. Use only blue or black ink. Do not use Red ink to complete claims or attachments.
2. Make sure the ink is dark enough to be picked up by the scanner. Times New Roman font is preferred.
3. All information must be legible, typed (preferably) or printed, and within the boxes. Please make sure information does not touch or cover the lines or writing on a claim.
4. Do not use highlighter on claims or attachments.
5. Submit claims and attachments on 8½ X 11 paper. If any item is smaller or larger than this size, you will need to copy it so it is on 8½ X 11 paper.
6. Do not submit carbon copies of claims or attachments.
7. The claim or attachments cannot have any dark smudges or dark print that runs together.
8. Do not place any stickers on the claim.
9. Do not submit two-sided documents.
10. Do not use whiteout on claims.
11. Only one line of service is allowed per detail line on the claim form. Do not bill with two service lines compressed into one detail line.
12. Do not use dashes or slashes in the Recipient ID, Patient Account Number or other fields.
13. The Revenue Code cannot be greater than three positions. Do not enter a leading zero.
14. When submitting multiple-page claims, you MUST follow these guidelines:

The following fields must match on all pages of a multiple page UB-92:

Statement Covers Period (box 6)
Provider ID (box 51)
Diagnosis codes and principle procedure code

- ** Special Note regarding Total Charges.** Total Charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim must be filled in. Note on the claim "Continued" or "Page 1 of 2", etc.

The following fields must match on all pages of a multiple page HCFA 1500:

Recipients Medicaid ID Number (box 1a)
Recipients Medicaid Name (box 2)
Patient Account Number (box 26)
Provider Name and Number (box 33)

- ** Special Note regarding Total Charges.** Total charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim must be filled in. Note on the claim "Continued" or "Page 1 of 2", etc.

USING THE MEDICAID FEE SCHEDULE

When billing Medicaid, it is important to use the Department's DME fee schedule in conjunction with the detailed coding description listed in the current HCPCS Level II coding books. In addition to covered services, fee schedules often contain helpful information such as when a prior authorization or CMN is required. Current fee schedules are available on the [Provider Information](#) website (see [Key Contacts](#)).

MISCELLANEOUS/NOT OTHERWISE SPECIFIED HCPCS CODES

Most HCPCS Level II coding categories have miscellaneous/not otherwise specified codes (e.g., equipment, orthotics, prosthetics, supplies, etc.). Providers must determine if an alternative HCPCS Level II code better describes the item being reported. These codes should only be used if a more specific code is unavailable. Claims containing a miscellaneous/not otherwise specified HCPCS must have one of the following:

All miscellaneous codes must receive prior approval. The prior must contain a statement from the provider that a specific HCPCS code is not available. If the miscellaneous item is a custom item, the prior must also contain an itemized statement to show cost of supplies used to fabricate and a statement to support why a prefabricated item is not suitable.

Claims containing miscellaneous/not otherwise specified HCPCS codes are subject to prepayment review. Review of these claims may result in processing and payment delays. Claims processing staff are dedicated to processing claims as quickly as possible to avoid lengthy delays in payment. Providers must provide an attachment with clear and complete descriptions for all HCPC codes to assist in minimizing delays. For more information on claim status, see the *Remittance Advices and Adjustments* chapter in the [General Information for Provider Manual](#).

Prepayment review is not a prior authorization process before delivery of the item and the payment of a claim does not mean that the item/service was reviewed for its necessity and/or appropriateness. Paid claims are subject to retrospective review auditing.

CLAIM INQUIRIES

Contact [Provider Relations](#) (see [Key Contacts](#)) for questions regarding:

- Recipient eligibility
- Payments
- Denials
- General claim questions
- Billing instructions

THE MOST COMMON BILLING ERRORS AND HOW TO AVOID THEM

Paper claims are often returned to the provider before they can be processed, and many others are denied because they include errors. To avoid returns and denials, double check each claim form to confirm the following items are included and accurate. See the [General Information for Providers](#) manual for full details on how to prevent returned and denied claims.

Common reasons why claims are returned to provider before processing:

- Medicaid provider number missing or invalid
- Incorrect claim form used
- Information on the claim form not legible

Common reasons for denied claims:

- Recipient number not on file, or recipient was not eligible on date of services
- Duplicate claim
- Prior authorization number is missing (The PA number must be provided in block 23 of the CMS/HCFA 1500 claim form)
- TPL on file and no credit amount on claim
- Claim past 365-day filing limit
- Missing Medicare EOB/Insurance EOB's
- Provider is not eligible during date of services, or provider number terminated
- Type of service not allowed for provider type
- Claim does not match prior approval exactly. (Example: Modifier missing or used inappropriately)

THIRD PARTY PAYMENT BILLING INSTRUCTIONS

Please Note: Any claims with TPL received after May 1 2005, will need to be billed to ND Medicaid in the following manner:

Provider must bill their usual and customary charge to ND Medicaid.

- The **TOTAL CHARGES** would be their provider's usual and customary charges.
- The **AMOUNT PAID** would be the actual payment received from the primary payer.
- The **BALANCE DUE** would be the TOTAL CHARGES less the AMOUNT PAID.

If the AMOUNT PAID amount is less than the ND Medicaid allowable amount, ND Medicaid will pay the difference up to the ND Medicaid allowable amount.

If the AMOUNT PAID is greater than the ND Medicaid allowable amount, ND Medicaid makes no payment.

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MEDICAL, DENTAL OR PHARMACY REMITTANCE ADVICE EXAMPLE

(1)09/17/04		NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES	
		MEDICAL ASSISTANCE	
(2)Provider Number 012345		REMITTANCE ADVICE	
(3)Check Number 00000001		(4)Page 1	
		(5)R/A Number 14	
(6) Main Street Clinic Anytown, USA			

Control No.	ID Number	Recipient Name	Case Number	Pat. Control Num	Prog. ID			
P.Phys	Service Dates	RX. No.	Service Code/Mod	QTY	Billed	RL/OI	Payment	MSG
(7)	(8)	(9)	(10)	(11)				
1	1004162304510	000-11-1234	Mouse Mickey	02-00015-007	415503840			
(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	
2	000052565	052604-052604	99214	1.0	132.00	.00	.00	22
(20)	TPL Carrier Code: 0382 Name: Workers Compensation							
(7)	(8)	(9)	(10)	(11)				
1	1004162304500	000-00-5555	Duck Daisy	23-00023-203	041550106			
(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	
2	000036529	052404-052404	99243	1.0	177.00	.00	96.17	N14
(21)	Collect this co-pay amount from the recipient							2.00
(22)	TOTAL CHARGE/Payment Amounts			2	309.00		96.17	

(23) Explanation of message codes used above

22 Payment adjusted because this care may be covered by another payer per coordination of benefits

N14 Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount

REMITTANCE ADVICE DESCRIPTION

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RA's accompany payment for services provided. The RA provides details of all transactions that have occurred during the previous week. Each line of the remittance advice represents all or part of a claim, and explains exactly what has happened to the claims, (paid, denied) and the reason the claim was denied.

FIELD	DESCRIPTION
1. Date	The date the RA was issued.
2. Provider number	The 6-digit number assigned to the provider after enrollment.
3. Check or ACH number	System assigned # to check or Automated Clearinghouse (ACH) transaction.
4. Page number	The page number of the RA.
5. RA #	State assigned number.
6. Provider name and address	Provider's business name and address as recorded with the Department.
7. Internal control number (ICN)	Each claim is assigned a unique 13-digit number (ICN). Use this number when you have any questions concerning your claim.
8. Recipient ID	The client's Medicaid ID number.
9. Name	The client's name.
10. Case #	The 10-digit number assigned by the local county social service agency.
11. Patient control #	The number assigned by the provider.
12. Performing Physician	The number assigned to the performing provider.
13. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same will appear in both columns.
14. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
15. Unit of service	The number of services provided under this procedure code.
16. Billed charges	The amount a provider billed for this service.
17. Recipient liability or other insurance	Amount deducted due to recipient liability or other insurance payment.
18. Payment	Medicaid's allowed amount.
19. Message/Explanation of Benefits (EOB)	A code that explains how or why the specific service was denied or paid. These codes and their meanings are listed at the end of the Remittance Advice.
20. Third Party Liability (TPL)	If applicable, name of third party payer will be listed.
21. Co-pay/deductible information	Indicated amount deducted that is recipient responsibility.
22. Total charge/payment amount	Total of claims on remittance advice, and total of charges billed by provider.
23. Explanation of message codes used above	Summary of codes that were used to pay or deny a service.

REBILLING AND ADJUSTMENTS

See the [General Information for Providers](#) manual for full explanation and procedure on how to request an adjustment or rebill.

To access the forms for rebilling and adjustments, select the appropriate link below:

[SFN 639 PROVIDER REQUEST FOR AN ADJUSTMENT](#)

[SFN 640 PHARMACY REQUEST FOR AN ADJUSTMENT](#)

[SFN 1115 DME PRIOR APPROVAL](#)

WHAT IS RECIPIENT LIABILITY

Recipient liability is the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. This is a monthly amount that is the recipient's responsibility to pay towards their medical claims.

Eligibility workers at the local county social service agency determine Medicaid eligibility for applicants, based on established federal and state guidelines. Eligibility determinations involve various criteria, which include:

- Family size
- Income
- Assets
- Expenses

These factors and any other program specific standards are calculated and compared against the family's income standard, as determined by program policy. When an individual's income exceeds the assistance-program income standards, that person can still become eligible for Medicaid with recipient liability. The individual must incur medical expenses that equal or exceed the recipient liability amount during the month. Providers should submit all claims for recipients with a recipient liability in the usual manner. As claims are received and processed, they are applied to the recipient liability amount. The recipient is obligated to pay the provider directly for any amount applied to the recipient liability. The provider will be notified on their remittance advice once the claim has been processed. The recipient is also notified of the requirement to make payment to the provider.

TAKING RECIPIENT LIABILITY (RL) AT THE TIME OF SERVICE

Providers are not to collect Recipient Liability at the time of service. Rather, providers are to:

- File the claim first
- Collect the RL only if directed by the information on the Remittance Advice.

WHAT IS THE FUNCTION OF SURS

The Department's Surveillance/Utilization Review Section (SURS) is a federally mandated program that performs retrospective review of paid claims. SURS is required to safeguard against unnecessary and inappropriate use of Medicaid services and against excess payments. If the Department pays a claim and later discovers that the service was incorrectly billed or the claim was erroneously paid, the Department is required by federal regulation to recover any overpayment. Referrals are received from the following sources or processes:

- Providers
- Clients
- Department staff
- Other agencies such as Medicare
- Legislators
- Private citizens
- Internal data reports

DESK AUDITS

When a desk audit is completed, SURS will determine the corrective action to stop an activity and recoup any overpayments. See the [General Information for Providers](#) manual for full details.

KEY POINTS

- Providers are encouraged to use the [Provider Relations](#) Unit for questions on how and what to bill.
- The provider is ultimately responsible to choose the code that matches the item/service provider or check with their supplier for the appropriate codes.
- Medicaid is entitled to recover payment made to providers when a claim was paid incorrectly for any reason.
- Medicaid can go back six years when conducting audits.
- Medicaid may withhold payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid provider agreement, federal and state laws, regulations and policies.
- Prior authorization does not guarantee payment; a claim may be denied or money paid to providers may be recovered if the claim is found to be inappropriate.

BILLING TIPS

The best way to avoid an audit is to make sure all claims are billed accurately. The following suggestions may help reduce billing errors:

Be familiar with the current Medicaid provider manuals. If you do not have one, you may request one from [Provider Enrollment](#) or check the web for the manual:

- <http://www.nd.gov/humanservices/services/medicalserv/medicaid/> select Medicaid Provider Information, and accept the “End User Agreement for Providers.”
- Be familiar with the prior authorization process
- Use current Level II HCPCS, and ICD-9 coding books, and refer to the long descriptions.
- Maintain complete records
- Attend classes on coding offered by certified coding specialists
- Utilize training offered by Medicaid. The appropriate staff should access Medicaid newsletters and other training programs offered.
- Avoid billing for the same supply twice. Duplicate billings delay the processing time of claims.
- Use specific codes and not miscellaneous codes
- Bill only for services covered by Medicaid
- Bill only under your own provider number
- Bill only for services that you provide
- Make sure to use modifiers when appropriate

DEFINITIONS AND ACRONYMS

This section contains definitions, abbreviations, and acronyms used in this manual.

Accessory

A medically necessary device or supply, which augments or compliments the functions of the equipment to which it is connected.

Acquisition Cost

The price that a provider pays for an item, which would include group rates, discounts, or sales.

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, such as TPL are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Capped Rental

Rentals classified by North Dakota Medicaid as capped rental items are limited to a specified rental period. All necessary supplies needed to operate the rented equipment item are included in the rental amount. No additional allowances are made, unless specified otherwise in the guidelines.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs. Formerly the

Health Care Financing
Administration (HCFA).

Certificate of Medical Need (CMN)

CMN form contains all the information needed for the Utilization Review personnel to determine if an item is medically necessary for the Medicaid Recipient.

Claim Form or Electronic Billing

The health insurance billing form or the electronic transmission of billings.

DMEOPS

Durable Medical Equipment, Orthotics, Prosthetics, and Supplies

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Coinsurance

The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage).

Copayment

The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Durable Medical Equipment –

Items that are used primarily and customarily for a medical purpose, are suitable for use in the home, are able to withstand repeated use, and would not ordinarily be of use in the

absence of illness, injury, or disability. Items in this class include but are not limited to orthotics, prosthetics, hearing aids, oxygen concentrators, apnea monitors, wheelchairs, and walkers. Eyeglasses and dentures are covered under the program but are listed in other manual chapters.

Eligible recipient – An individual who meets all eligibility requirements for the North Dakota Medicaid Program.

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

HCPCS – The Health Care Common Procedure Coding System. These codes are required for prior authorization of and billing for durable medical equipment or supplies.

Hearing aid – An apparatus or instrument that amplifies sound for persons with impaired hearing.

Individual Adjustment

A request for a correction to a specific paid claim.

Maximum Allowable

The maximum dollar amount for which a provider may be

reimbursed as established by North Dakota Medicaid for specific services, supplies, and/or equipment.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering, or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Neurologist – A physician specializing in diseases of the nervous system.

Orthopedic surgeon – A physician specializing in surgery for the prevention and correction of deformities involving the limbs.

Orthopedist – A physician specializing in orthopedics.

Orthosis – An orthopedic appliance, brace, or splint used to support, align, prevent or correct deformities or improve the function of movable parts of the body.

Physiatrist – A physician specializing in physical medicine.

Physician – A person licensed to practice medicine.

Podiatrist or chiropodist – A licensed individual who specializes in the diagnosis, treatment, and prevention of conditions of the foot.

Primary Care Provider (PCP) per North Dakota Medicaid policy – A physician, rural health clinic, Indian Health Service facility or other practitioner named by a recipient as his or her primary health care provider.

Prior authorization (PA) – A written approval by the Department for appropriate medical services, equipment, or supplies before such items are ordered or purchased. A CMN and a physicians order or prescription must be attached to the PA request.

Prosthesis – An artificial substitute to replace or augment a body part including, but is not limited to, eyes, arms, hands, legs, feet or breasts. Prior authorizations are required for these items.

Prosthetist – A person who is certified in making artificial limbs and other body parts.

Private-pay

When a client has on insurance/health care coverage and pays for medical services out of his or her own pocket.

Provider or Provider of Service

An institution, agency, or person: Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and eligible to receive payment from the Department.

Purchase Price Rental – a medical term that limits rental payments to no more than the amount paid by the department to purchase the item. All supplies needed to operate the equipment are included in the rental fee.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Rheumatologist – A physician specializing in disorders marked by inflammation, degeneration, or metabolic derangement of the connective tissues especially joints and related structures.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Specialist – A physician, preferably board certified, whose practice is limited to a specific type of medicine or surgery by advanced training.

Supplies – Medically necessary expendable items that are ordinarily used and replenished on a regular basis. Supplies include, but are not limited to, ostomy appliances, catheters, and oxygen.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid client.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information, documentation from, or action by the provider) to Medicaid within the latest of 12 months from whichever is later:

- the date of service
- the date retroactive eligibility or disability is determined

- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the

adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item. ♦

APPENDIX A – PROVIDER ENROLLMENT FORMS

Forms that need to be completed by the providers and mailed to Provider Enrollment.

PROFESSIONAL

- DN 622 Provider Enrollment Package (see Appendix A for copy)
- SFN 973 Enrollment Questionnaire ***
- W-9 Form located on IRS web site at <http://www.irs.ustreas.gov/formspubs/index.html>
- SFN 615 Medicaid Program Provider Agreement ***

PHARMACY

- DN 622 [Provider Enrollment](#) Package (see Appendix A for copy)
- SFN 973 Enrollment Questionnaire ***
- W-9 Form located on IRS web site at <http://www.irs.ustreas.gov/formspubs/index.html>
- SFN 1169 Pharmacy Agreement ***

OUT-OF-STATE PROVIDERS

- DN 622 [Provider Enrollment](#) Package (see Appendix A for copy)
- SFN 973 Enrollment Questionnaire ***
- W-9 Form located on IRS web site at <http://www.irs.gov/pub/irs-fill/fw9.pdf>
- SFN 615 Medicaid Program Provider Agreement ***
- SFN 509 Out of State Enrollment Clarification Form ***

***Form available on the web: www.state.nd.us/eforms/

APPENDIX B – NON COVERED-NO EXCEPTION ITEMS

The following is a list of some generic categories/items specifically determined not reimbursable by State Plan (general) Medicaid: This list may not be all-inclusive:

ADAPTIVE EQUIPMENT FOR DAILY LIVING

- Alarms or environmental controls: Telephone, door, appliance, computer, and television
- Bath/Shower chair
- Belts: Personal, transfer, walking
- Hip boards/Transfer boards
- Injectors
- Jar openers
- Magnifying lenses
- Medi-planners
- Off the shelf shoes that could be purchased at general retail stores
- Pivot machine
- Plate guards
- Plates
- Raised toilet seat
- Reachers
- Scooters: 2, 3 and 4 wheel
- Tongs, eating utensils
- Tub stool/bench
- Walking sticks
- Wheelchair: Second or third chair, manual or electric, regardless of purchaser
- Wheelchair modifications to accommodate vehicles
- Wheelchair puller
- Whirlpools
- Writing guides

BUILDING MODIFICATIONS

- Wheelchair ramps
- Widening of doorways
- Ceiling/wall mounted equipment
- Rails
- Elevators and stair lifts

AUTOMOBILE MODIFICATIONS

- Lifts
- Controls
- Restraints
- Seats
- Compasses
- Tie-downs

ENVIRONMENTAL CONTROL DEVICES

- Switches
- Controls
- Telephones: Including telephone lights and alarms
- Air filter/conditioner/purifier
- Battery clubs: Hearing aid
- Car seats
- Control units for environmental equipment
- Dehumidifiers: Room or central
- Humidifiers: Except for oxygen
- Vaporizers
- Hot tubs
- Swimming pools

EXERCISE EQUIPMENT

- Bicycles: Exercise
- Dumbbells
- Equipment: Including in-home physical therapy items, pulleys, ropes, weights, and balls
- Treadmill
- Weight Machines
- Wrist/hand strengthening

MISCELLANEOUS ITEMS

- Beds: Except for hospital and short term restorative specialty beds
- Bed board
- Blood pressure equipment: Except for renal dialysis patients
- Chairs: Laminectomy
- Compression stockings and lymphadomal equipment
- Masks: Except oxygen administration and burn
- Pump: Electric breast pump
- Scales
- Strollers

- Standing Frames

PERSONAL CARE ITEMS

- Clothes: Disposable, wash, wipes
- Deodorants
- Egg crate mattress
- Eye pads
- Food blenders and processors
- Gloves
- Hot packs
- Ice packs, collar, etc
- Lamps
- Leg bag drainage system for electric wheelchair
- Mattresses: Except hospital beds
- Mattress pads: Except for hospital beds
- Monitor: Home uterine
- Nylon aid
- Pads: Heat, cold
- Paper: Toilet, facial tissues
- Pediatric cribs
- Personal need, over the counter items: Razors, tweezers, toothbrushes (electric and non-electric) and toothpaste, toothettes, cotton swabs, lotions, creams and occasional use products, sanitary products, nursing pads, tampons, shampoo, soap, toiletries, Ted hose, panty hose, shoe horns, wedges, foam toe pads and all other non-custom shoe or foot items
- Pocket Talkers
- Shoes: Tennis shoes or non-customized shoes. Includes extra depth and extra width shoes unless required for customized orthotic
- Tables: Including over the bed
- Toys
- Water bottles
- Water pics

MEDICAL ALERT BRACELETS

CONVENIENCE OR COMFORT ITEMS: For the individual or caregivers benefit

- Bottles: Hot water, nursing
- Button aids
- Carafes
- Diapers for persons under the age of 4

- Disinfectants: Room, nebulizers
- Elastic laces
- Emesis basins
- Head bands
- Massage devices
- Reachers
- Sock nylon aids
- Sponges: Bath
- Swim plugs
- Vaporixer

INSTITUTIONAL EQUIPEMENT

- Medical supplies used by home health
- Paraffin baths
- Psoriasis lamps

EDUCATIONAL EQUIPMENT

- Books
- Pamphlets
- Brochures
- CDs, tapes, videos
- Computers and printers: Except assistive communication devices

APPENDIX C – GUIDELINES

The guidelines below are to help guide providers in determining if North Dakota Medicaid would potentially reimburse a given piece of DME. Every effort has been made to try to maintain accuracy of these guidelines. Absolute accuracy cannot be guaranteed; therefore, Medicaid reserves the right to add, change, or delete guidelines. The guidelines listed below **MAY NOT** be all-inclusive. Additions or deletions to the guidelines will be posted to the Departments' provider website via the update link. It is the provider's responsibility to check this web site periodically to maintain an updated manual.

If Medicaid is the primary payer, the Department will determine if rental or purchase of the equipment ordered is appropriate and the most cost effective. Certain items, which are listed below and identified on the provider price file, require a Physician signed Certificate of Medical Necessity (CMN). The Department reserves the right to request additional documentation beyond the CMN when necessary.

REMINDER: THE GUIDELINES MAY NOT BE ALL INCLUSIVE. IF YOU ARE UNSURE IF A PIECE OF EQUIPMENT/SUPPLY MIGHT BE COVERED, OBTAIN A PRIOR AUTHORIZATION BEFORE SUPPLYING THE CLIENT.

APNEA MONITORS: CMN REQUIRED (Form number to be assigned). *Prior authorization required.*

At least one of the following conditions must be present for coverage:

- A sibling has died from SIDS
 - Infant has significant apnea of 20 seconds or longer
 - Infant has mild to moderate apnea and desaturates below 90%
 - Infant has periodic breathing with desaturation below 90%
- Initial coverage allowed for a 6-month period.
 - Documentation must support the above criteria.
 - The physician order and supporting documentation must accompany the prior authorization when requesting continued rental.
 - Approval will be granted only if the infant continues to have significant alarms, or unresolved apnea.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS:

Coverage allowed if the following conditions are present:

- Contracture of the ankle with reasonable expectation to correct the contracture, and
 - Contracture is expected to interfere significantly with the patients functional abilities, and
 - Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons, and/or
 - Weakness or deformity of the foot and ankle that require stabilization for medical reasons and have potential to benefit functionally (i.e., foot drop)
- Static AFO will be denied as not medically necessary, if the contracture is fixed.
 - Replacement interface is covered if the AFO is allowed. Limited to a maximum of one per year.
 - KAFO is covered for ambulatory patients for whom an AFO is covered and for whom additional knee stability is required.
 - Replacement is allowed if change in client's condition, irreparable accidental damage or growth. A new prior authorization is required with the reason for replacement documented on the prior.
 - All labor involved in replacing an orthosis is included in the allowance for that component.

AFO AND KAFO, CUSTOM:

Coverage allowed if the following conditions are present:

- Any one of the listed conditions for an Ankle-Foot/Knee Ankle Foot Orthosis, and

- The patient could not be fitted with a prefabricated AFO, or
 - Condition necessitating the orthosis is expected to be permanent or lasting more than 6 months, or
 - Documented neurological, circulatory or orthopedic status that requires a model to prevent tissue injury, or
 - The patient has a healing fracture which lacks normal anatomical integrity, or
 - There is a need to control the knee, ankle or foot in more than one plane.
- Replacement allowed if change in patients' condition, irreparable accidental damage, or growth. Reason must be documented on the prior authorization.
 - All labor involved in the replacement of the orthosis is included in the allowance for that component.
 - For a custom-fabricated orthosis, there must be documentation in the supplier's records to support the medical necessity of that type of device rather than a prefabricated orthosis. An itemized cost statement for supplies must accompany the prior.
 - When the code L2999 is priored, the prior must include a narrative description of the item and information justifying the medical necessity for the item.
 - A static AFO is non-covered when used solely for the prevention or treatment of pressure ulcers, or treatment of edema. No exceptions
 - Socks used in conjunction with an orthosis are covered. Limited to two every 6 months.
 - The right and left modifiers must be used for the request of the orthosis, any additions, and replacement parts

BILIRUBIN LIGHTS:

To be updated at a later date.

BREAST PUMPS:

Coverage allowed if the following conditions are present:

- Ordered by a physician, and
 - A nursing mother experiencing separation from her infant because of work, school, illness, or any other medical reason.
- Manual pumps only.

BLOOD GLUCOSE MONITORS:

Coverage allowed if ALL of the following conditions are present:

- Diabetic (type I, II, or gestational), and
- There is a physician's order for the monitor and supplies, and
- The patient has successfully completed training in the use of the monitor, test strips and lancets, and
- The device is designed for home use.

- The physicians order must include all items to be dispensed, the specific frequency of testing, the treating physician's signature and the date of the physician's signature.
- One monitor allowed every 4 years, if replacement is needed.
- Lancets (A4259), blood glucose test strips (A4253) and control solutions (A4256) are covered items as well as the spring powered device (A4258) for lancets.
- Allowed up to 150 strips/lancets per month for insulin dependent diabetics.
- Allowed up to 200 strips/lancets every 3 months for non-insulin dependent diabetics.
- Allow one spring-powered device (A4258) every 6 months, if necessary.
- Laser skin piercing device (E0620) is non-covered as not medically necessary. No exceptions
- Alcohol, betadine, or peroxide is non-covered; since these items are not required for the proper functioning of the device.
- Urine test strips (A4250) are non-covered since they are not used with a glucose monitor. No exceptions

CANE/CRUTCHES:

Coverage allowed if the following condition is present:

- Impaired ambulation with potential for improved ambulation.
- Limited to one every 7 years.
- A white cane for a blind person is non-covered since it is a “self-help” item. No exceptions
- Do not use E1399 to code any type of cane or crutch. Use the specific HCPC code.

CERVICAL TRACTION HOME DEVICES:

Coverage allowed if the following condition is present:

- Musculoskeletal/neurological impairment requiring traction equipment.
- Ordered by a physician

CHEST WALL OSCILLATING DEVICE (AIRWAY VEST SYSTEM): CMN REQUIRED (Form number to be assigned) *Prior authorization required*

Coverage allowed if the patient is unable to cough or remove phlegm on his or her own, and must have one of the following:

- Diagnosis of moderate or severe cystic fibrosis, or
- Ciliary dyskinesia, or
- Bronchiectasis, or
- Neuromuscular disorder (Muscular dystrophy, Multiple Sclerosis, ALS)

Approval also based on the following questions:

- Does the recipient currently have a vest/generator?
- What other bronchial drainage device/treatment has been tried, and how did it fail?
- Can the recipient use the vest effectively?

- Does the vest/generator meet all the bronchial drainage therapy needs?
- What is the frequency of antibiotics or hospitalizations and the associated costs over the past one year?
- Initial approvals will be given for a three to six month trial period.
- Renewal requests should document patient compliance, update the therapy plan and current medications, and provide a history of hospitalization during the trial period.
- NDMA will not reimburse providers for bronchial drainage performed by a therapist or any other health care professionals while the recipient has a functional bronchial drainage vest. It is also recommended that the family members maintain their manual chest percussion therapy (CPT) skills.

- Only one compressor allowed per household. No exceptions

COLD THERAPY:

Non-covered/no exception

COMMODOES/CHAIRS:

Coverage allowed if the following condition is present:

- The patient is physically incapable of utilizing regular toilet facilities. The patient is confined to a single room, to one level of the home and there is no toilet on that level, or he/she is confined to the home and there are no toilet facilities in the home.
- Extra wide/heavy duty (E0168) allowed, if patient weighs more than 300 lbs.
 - Mobile chair (E0164, E0166) is not medically necessary and is non-covered/ no exceptions.
 - Commode chair with detachable arms (E0165) allowed if necessary to facilitate transferring the patient.
 - Commode chair with seat lift mechanism (E0170, E0171) is non-covered/ no exceptions.
 - Raised toilet seats are non-covered/ no exceptions.
 - A commode chair that is used as a raised toilet seat by positioning it over the toilet is non-covered/ no exceptions.
 - Footrest (E0175) is non-covered. Not medical in nature/ no exceptions.
 - Limited to one commode every 7 years.

CPAP: CMN REQUIRED (Form number to be assigned). *Prior authorization required.*

A single level CPAP device (E0601) is covered if the following conditions are present:

- Diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram, and meets either of the following:
 - Apnea –Hyponea Index (AHI) is greater than or equal to 15 events per hour, or
 - AHI is from 5 to 14 events per hour with documented symptoms of:

- Excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, or
 - Documented hypertension, ischemic heart disease or history of stroke, and
 - For OSA a single level device has been tried and proven ineffective.
- Initial approval will be for 3 months only and then if documentation supports that the patient is compliant and the therapy is effective the request for continued rental or purchase will be allowed. Compliance is defined as using the device 4 out of 24 hours and 20 days out of the month.
 - Polysomnographic studies must be performed in a sleep study laboratory NOT in a home or mobile unit.
 - Arterial blood gases, sleep studies, and sleep oximetry; MUST NOT be performed by the DME supplier
 - A heated (E0561) or non-heated (E0562) humidifier will be covered.
 - Included during rental: Compressor, manometer, CPAP Valve (if separate from mask), filters, fuses, tubing, cushions, pillows, nasal cannula's, chin straps. A mask (A7030) and headgear (A7035) will be paid separately during the rental period. Quantities allowed are two per year for A7030 and A7035.
 - Billed separately when patient owned equipment: Replacement parts, headgear, mask and supplies listed below.

The following represents the usual maximum amount of accessories expected to be medically necessary:

- | | |
|-------------------------------------|-------------------------------------|
| • <u>A7030</u> 1 per 6 months | • <u>A7036</u> 1 per 6 months |
| • <u>A7031</u> 1 per month | • <u>A7037</u> 1 per month |
| • <u>A7032</u> 2 per month | • <u>A7038</u> 2 per month |
| • <u>A7033</u> 2 per month | • <u>A7039</u> 1 per 6 months |
| • <u>A7034</u> 1 per 3 months | • <u>A7046</u> 1 per 6 months |
| • <u>A7035</u> 1 per 6 months | |

DISPOSABLE DIAPERS, LINERS/PADS, AND UNDERPADS: *Prior authorization required.*

Coverage allowed is the following condition is present:

- Over the age of 4 with an underlying medical condition that involves loss of bowel or bladder control.
- Physicians order is required and must include the duration of need and the medical reason.
 - Diapers limited to 180/month.
 - Liners limited to 70/month.
 - ICF/MR and skilled nursing facility residence are excluded, as the products are included in the facility per diem.
 - Only a one-month supply may be dispensed at any time.

ENCLOSED BED:**Non-Covered**

If a specialty bed is physician ordered and deemed medically necessary due to the clients medical condition, and before Medicaid will consider coverage, a home evaluation with recommendations by a Licensed Occupational Therapist must take place.

ENTERAL NUTRITION: CMN REQUIRED (CMN 782). *Prior authorization required*

Nutritional products may be approved when criteria for both 1 and 2 are met:

- The diagnosis can be linked to the need for the nutritional product, and:
- There is a failure to thrive diagnosis with an underlying diagnosis (i.e., cerebral palsy with uncoordinated swallowing), or
- Severe dysphasia, crohns disease, swallowing disorders, cancer, or
- Complete allergy to breast milk, cow's milk, soy milk, and another condition such as cystic fibrosis, or
- There is a permanent non-function or disease of the structures that normally permit food to reach the small bowel, or
- Disease of the small bowel which impairs digestion and absorption of an oral diet and expected to last more that 3 months, and
- The request is for 51% or more of their daily nutritional intake.

Additional covered items:

- Food thickeners
- Some enteral patients may experience complication associated with syringe or gravity method of administration and require a more controlled administration method. The pump will be covered if medically necessary and ordered by the physician.
- Supply Kits (B4034-B4036): Must correspond to the method of administration. Allowed one supply kit per day or maximum of 31 per month. Supply kits include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day.

Non-Covered Nutritional Products:

- Nutritional products for healthy newborns
 - Standard infant formula for children under the age of one
 - Nutritional products for persons living in LTC facilities (enteral products are included in the per diem)
 - Sport shakes
- More than one gastrostomy/jejunostomy tube, or three nasogastric tubes every 3 months is rarely medically necessary.
 - Dressings/anchoring devices are included in the supply kit and will not be paid separately.

- A revised CMN is necessary if the number of unit per month, method of administration, route of administration or type of formula is changed.
- Recertification yearly unless required earlier due to change in orders/quantity.
- No more than one month's supply of enteral nutrients, equipment or supplies are allowed for one month's prospective billing.

EXERCISE EQUIPMENT:

Exercise equipment including in home physical therapy items, pulleys, weights, ropes, balls, bicycles, treadmills, scooters and related items are non-covered/ no exceptions.

EXTERNAL BREAST PROSTHESIS:

Coverage allowed if the following condition is present:

- Mastectomy patients
 - Allow 4 prosthetic bras per year.
 - Replacement allowed if irreparable damage.
 - Allow one per side.
 - Need to use the RT/LT modifier.
 - Can be replaced every 2 years for silicone and every 6-months for fabric, foam, fiber.

EXTERNAL INFUSION PUMPS: CMN REQUIRED (SFN 780). *Prior authorization required*
Coverage allowed if all criteria are met:

- Administration of any drug that is medically necessary, reasonable and prescribed by a physician; such as:
 - Deferoxamine for iron overload
 - Chemotherapy for the treatment of primary hepatocellular or colorectal cancer
 - Morphine when used for the treatment of intractable pain
 - Continuous subcutaneous insulin for the treatment of diabetes mellitus and has
 - Positive beta cell auto-antibody test, and
 - C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method, or
 - For patients with renal insufficiency and a creatinine clearance less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 percent of the lower limit of normal of the laboratory's measurement method, and
 - The patient has completed a comprehensive diabetes education program, has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple injection regimen.

- Three documented glycosylated hemoglobin levels greater than 7%
 - A history of recurring hypoglycemia
 - A wide fluctuation in blood glucose before mealtime
 - A dawn phenomenon with fasting blood sugars frequently exceeding 200mg/dl
 - A history of severe glycemic reactions, and
 - Parenteral administration of the drug in the home is reasonable and necessary, and
 - An infusion pump is necessary to safely administer the drug, and
 - Systemic toxicity or adverse effects of the drug is unavoidable without infusing it at a strictly controlled rate.
- An IV pole (E0776) is covered only when a stationary infusion pump (E0791) is ordered.
 - Supplies for the maintenance of a parenteral drug infusion catheter (A4221) are covered.
 - Supplies used with an external infusion pump (A4222, K0552) are covered. Not more than one cassette or bag or prepared syringe per dose of each drug.
 - Supplies used with an external insulin infusion pump (A4221, and K0552) are covered for the period of covered use.
 - Drugs and related supplies/equipment billed by a supplier who does not meet the above stated criteria will be denied as not medically necessary.
 - If there is a change in the drug being administered, a prior authorization and a revised CMN must be submitted for review.
 - Backup pumps will be denied as not medically necessary.
 - If a patient begins an infusion for one drug and subsequently the drug is changed or another drug is added, a revised CMN must be submitted for use of the pump with the new or additional drug.
 - Disposable drug delivery systems are non-covered devices because they do not meet the definition of durable medical equipment.
 - A4221: Includes dressings for catheter site, flush solutions, cannulas, needles, dressings and infusion supplies. Allowed one unit per week. Catheter insertion devices for use with external insulin infusion pump infusion cannulas are included in the allowance for code A4221 and are not separately payable.
 - A4222: Includes the cassette or bag, diluting solutions, tubing, port cap changes, compounding charges, and preparation charges. Allowed one cassette or bag for each dose of drug administered.
 - A4230 and A4231 are not valid for claim submission because they are included in code A4221.

EYE PROSTHESIS:

Coverage allowed if the following condition is present:

- Absence or shrinkage of any eye due to birth defect, trauma or surgical removal.

- Replacement allowed every 5 years. Replacement of prosthesis prior to 5 years is covered if the prosthesis is irreparable damaged or stolen.
- One enlargement/reduction allowed.
- Need to use the RT/LT modifier.

FACIAL PROSTHESIS:

Coverage allowed if the following condition is present:

- Loss or absence of facial tissue due to disease, trauma, or congenital defect.
- Adhesive, adhesive remover, skin barrier wipes and tapes used in conjunction with a facial prosthesis are covered.
- Labor is included in the allowance of the prosthesis and will not be paid separately (includes cost of materials).
- Repairs are covered if accidental damage or extensive wear. If costs of repairs exceed 75% of the cost to replace, replacement is to be requested.
- Need to use the RT/LT modifier.

FIRST AID SUPPLIES:

- Limited to those used for post-surgical need, accidents, decubitus treatments, and long-term dressings. Individual supplies must be billed as separate items. First aid supply kits are not covered/no exception.

HEARING AIDS: ([SFN1115](#)) *Prior authorization required*

Coverage allowed if any of the following conditions are present:

- Hearing loss of at least 35 dB at frequencies 500 Hz, 1000 Hz, and 2000 Hz (Ave. of 35 dB) in ear with best hearing acuity on all patients 18 years and older, and
- Recipient has not had a hearing aid provided by Medical Assistance in either ear for at least five years.
- Full shell or behind the ear hearing aids only.
- Audiogram must be performed by an audiologist or licensed hearing aid dispenser and must be included with the Prior Authorization Request (PAR) form.
- One hearing aid for all new users over 18 years old except on previous binaural users.
- Make, model and cost options provided on DME form.
- Invoice cost must include all dealers' discounts/sales/specials.
- Hearing aids to be authorized will not exceed our maximum allowable. MA will review this cost periodically.
- Recipients under 18 years of age are allowed one hearing aid evaluation, and hearing aid replacement every 12 months; those over 18 are allowed one hearing aid evaluation every two years and replacement every 60 months.
- Lost hearing aids will not be replaced until their allowed replacement time of five years has expired.

- Hearing aids lost by recipients less than 18 years of age will be given special consideration by MA.
- Ear-molds do not need prior authorization.
- Repair charges under \$35 do not require an invoice. Repairs over \$200 continue to need prior approval.
- Monaural wearers will be allowed up to four batteries per month, binaural wearers up to eight batteries per month. Batteries do not require prior approval.

HOSPITAL BEDS: CMN REQUIRED (SFN 785). *Prior authorization required.*

Coverage allowed if the following condition is present:

- Patients condition requires positioning of the body to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections in ways not feasible in an ordinary bed, or
- Patient's condition requires special attachments that cannot be fixed or used on an ordinary bed, or
- A patient who requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.

Standard Hospital Bed (E0250, E0251, E0290, E0291): Must meet the criteria listed above. The CMN must document severity and frequency of symptoms of the condition that necessitate a hospital bed for positioning versus fixed attachments used on an ordinary bed.

Variable Height Bed (E0255, E0256, E0292, E0293): Must meet one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

Semi-Electric Feature (E0260, E0261, E0294, E0295): Allow if patient meets the criteria for a standard hospital bed, recipient's judgment and skill level must be adequate to operate the controls and functional limitations that precludes use of a conventional bed or a standard hospital bed. The CMN must clearly document why a standard hospital bed will not meet the clients medical requirements.

Total Electric Feature (E0265, E0266, E0296, E0297): Non-covered/ no exceptions.

Heavy Duty Bed (E0303): Allowed if patient meets the criteria for a standard bed and the patient is greater than 300 lbs.

Ordinary bed: Non-covered/ no exceptions.

*An ordinary bed is one, which is typically sold as furniture. It consists of a frame, box spring and mattress. It is a fixed height and has no head or leg elevation adjustments. An ordinary bed will accommodate most transfers to a chair, wheelchair or standing position. If needed, it can almost always be adapted to accommodate these transfers. The need for a particular bed height would rarely by itself justify the need for a hospital bed.

Accessories:

- Trapeze is covered if there is a respiratory condition, a need to change body position and to aid the patient to get in and out of bed.
- Bed Cradle is covered if there is a need to prevent contact with the bed covers.

- Side Rails are covered if required by the patients condition and used with a hospital bed.
- Mattress replacement is covered if the equipment is patient owned equipment.
- Bed board and over bed table are non-covered/no exception.

LOWER LIMB PROSTHESIS: ([SFN1115](#)) *Prior authorization required.*

Coverage allowed if ALL of the following conditions are present:

- Patient will reach or maintain a defined functional state within a reasonable period of time, and
- Patient is motivated to ambulate.

Accessories:

Covered when they aid in, or are essential to, the effective use of the artificial limb.

- Need to use the RT/LT modifier.
- A preparatory prosthesis is covered. Any component of the preparatory unit that can be reused on the permanent prosthesis must be used.
- The treating physician and/or the prosthetist, based upon the functional needs of the patient, must make a determination of the type of prosthesis dependant on the patient's functional level. Documentation must be provided to the Department at the time of the request to support the functional level of the client.
- Feet: L5987 is non-covered as it exceeds plan maximums.
- Knees: Electronic knees exceed plan maximums and are non-covered.
- Ankles: (L5982-L5986) are covered.
- Test sockets: For immediate prostheses they are not medically necessary and are non-covered. More than 2 test sockets for an individual prosthesis are not medically necessary unless there is documentation to justify the need.

MANUAL WHEELCHAIRS: CMN REQUIRED (SFN 781) *Prior authorization required*
Tilt'n Space (E1161):

Documentation of increased or excessive muscle tone related to the person's diagnosis and the condition is anticipated to be unchanging for at least one year.

Manual, fully reclining chairs:

Documentation of spinal cord impairments, inability to shift or recline to relieve pressure, or inability to tolerate full upright position.

Seating systems:

Skin protections cushions allowed if current pressure ulcer or past history of. Absent or impaired sensation in the area that contacts the seating surface and inability to carry out functional weight shift. Positioning seat cushion allowed if the patient has significant postural asymmetry.

Customized seating systems:

Documentation, which clearly explains why a prefab seating system is not sufficient to meet the patients seating, and positioning needs.

Power chairs (See Power Wheelchair Base):

Repairs:

When submitting for repairs, indicate when the chair was purchased. Repairs are covered only for patient owned wheelchairs. RP modifier must be used when submitting for repairs. One-month rental allowed if a patient-owned wheelchair is being repaired. Must use equipment specific code with the RR modifier. Example K0001RR

K0108:

Include narrative description of the item being repaired/requested.

If a specific code exists for any given piece of equipment, that code must be used rather than using the K0108 code.

- Crutch/cane holder (E2207) is non-covered as not medically necessary.
- Vehicle modifications to accommodate a wheelchair are non-covered/no exceptions.
- Anti-rollback device (E0974) is allowed if the patient propels self and needs the device because of ramps.
- Safely belts/pelvic straps allowed if weak upper muscles, upper body instability or muscle spasticity requiring this device for positioning.
- Limited to one wheelchair, manual or electric, every 5 years.
- Back-up wheelchairs will not be allowed, as they are not medically necessary.

NEBULIZERS:

Small volume nebulizer (A7003, A7005) and related compressor (E0570) are covered if:

- Any medical condition where it is medically necessary to deliver a prescribed medication; such as, COPD, Cystic Fibrosis, Asthma, HIV, etc.
- If none of the drugs used with a nebulizer are covered, the nebulizer will be denied as not medically necessary.

Large volume nebulizer (A7007) and related compressor (E0565) are covered if:

- Medically necessary to deliver humidity to a patient with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheotomy or tracheobronchial stent.
- Battery powered compressor: Non-covered as a convenience item. No exceptions
- Included in rental: Compressor, reusable nebulizer, tubing, mouthpiece, and mask.
- Billed separately: And only with patient owned equipment includes a replacement/disposable hand held nebulizer, replacement tubing, disposable mouthpieces, or face mask.
- Limited to 1 every 5 years.

The following table lists the usual maximum frequency of replacement of accessories with patient owned equipment:

- | | |
|--------------------------------|------------------------------|
| • <u>A4619</u> 1/month | • <u>A7006</u> 1/month |
| • <u>A7003</u> 2/month | • <u>A7007</u> 2/month |
| • <u>A7005</u> 1/6months | • <u>A7013</u> 2/month |

- A7014 1/3months
- A7015 1/month
- A7016 2/year
- A7525 1/month
- E1372 1/3years

OSTEOGENIC BONE STIMULATOR: CMN REQUIRED (SFN722). *Prior authorization required.*

Coverage allowed if the following conditions are present for the following devices:

Non-Invasive Stimulator: (E0747, E0748)

- Nonunion of long bone fractures after six months from the fracture date and healing has ceased for 3 or 4 months prior to starting therapy with the osteogenic stimulator.
- Failed fusion when a minimum of 9 months has lapsed since last surgery.
- Congenital Pseudarthrosis
- Multi-level spinal fusion (3 or more vertebra).

Ultrasonic Stimulator: (E0760)

Follow Medicare guidelines

Non-Covered If Diagnosis Of:

- Fresh fractures
- Fractures that are tumor related
- Fracture of the skull
- Requests must be from an orthopedic surgeon

OSTOMY SUPPLIES:

Coverage allowed if the following conditions are present:

- Colostomy
- Ileostomy
- Urinary Ostomies
- Quantity of supplies will vary depending on the type of ostomy, its location, its construction and the condition of the skin around the stoma.
- Liquid barrier is allowed (A4369).
- Continent stoma patients may use one of the following to prevent/manage drainage: stoma cap (A5055), stoma plug (A5081), or gauze pads (A 6216). No more than one type of supply would be medically necessary on a given day.
- Urinary ostomy patients may use either a bag (A4357) or bottle (A5102) for drainage at night. It is not medically necessary to have both.

OXYGEN EQUIPMENT: CMN REQUIRED (SFN729). *Prior authorization required.*

Coverage allowed if the following conditions are present:

- Severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
- The patient's blood gas study meets the criteria. Follow Medicare guidelines.

Portable Oxygen:

- Must meet the above criteria and must be mobile in the home and would benefit from portable oxygen in the home.

- Portable systems are non-covered for patients who qualify for oxygen solely based on blood gas studies obtained during sleep.

Oxygen Contents:

- Oxygen contents are included in the allowance for rented oxygen systems. Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a patient owned stationary gaseous or liquid system respectively. Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met, and:
 - The beneficiary owns a concentrator and rents or owns a portable system, or
 - Beneficiary rents or owns a portable system and has no stationary system (concentrator, gaseous, or liquid).

Accessories/Supplies:

- Accessories, including but not limited to, cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), humidifiers (E0555), included in the allowance for rented systems.
 - Only rented oxygen systems E0424, E0431, E0434, E0439, E1390RR are eligible for coverage.
 - The provider must provide any accessory ordered by the physician.
- A CMN is required for the initial order and re-certification is required for month 13 and then yearly. The submitted CMN must have the oxygen saturation documented and the oxygen saturation measurement must be within the last 30 days of initial certification and re-certification.
 - Use appropriate RR or NU modifier.
 - The units of service are to be indicated as one unit of service per month.
 - Travel oxygen - it is the recipients responsibility to arrange oxygen during their travels. Medicaid will only pay one provider for oxygen during any one rental-month.
 - Oxygen contents are included in stationary system reimbursement.
 - The portable contents are included in stationary system reimbursement for the stationary contents.

Oximeters and replacement probes: (E0445, A4606)

- Non-covered – No-exception.

PARENTERAL NUTRITION: CMN REQUIRED (SFN726). *Prior authorization required.*

Coverage allowed if ALL of the following conditions are present:

- Considered reasonable and necessary for a patient with permanent or severe pathology of the digestive tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.
 - Consist of at least 90% of the patient's daily nutritional intake.
- If a pump is required to deliver the nutritional supplement, reimbursement will be made for the simplest model that meets the medical needs of the patient as

established by the medical documentation. Only one pump will be covered at any one time.

- If all requirements have been met, the medically necessary nutrients, administration supplies and equipment are covered.
- The ordering physician must have seen the patient within 30 days prior to the initial certification. If unable to see the patient, documentation must accompany the prior auth stating the reason why and how the patient's enteral needs were evaluated.
- Requests for additional pumps will be denied as not medically necessary
- Special parenteral formulas (B5000-B5200) are non-covered/ no exceptions.
- No more than one-month's supply of parenteral nutrients, equipment or supplies is allowed for one month's prospective billing.

PATIENT LIFTS:

Coverage allowed if the following condition is present:

- Transfers require the assistance of more than one person and without the use of a lift the patient would be bed confined.
- Electric lift mechanism (E0635 or E0636) is non-covered/ no exceptions. Convenience feature. If coverage criteria for a patient lift are met, payment is allowed the same as E0630.
- Sling/Seat (E0621) is a covered item.
- Patient lift, bathroom or toilet (E0625) is non-covered/ no exceptions as a convenience item.
- Patient lift (E0639 and E0640) non-covered/ no exceptions. Not considered DME.
- Allowance not more than every 7 years.

PNEUMATIC PRESSURE DEVICES:

Non-covered/no exception

POWER OPERATED VEHICLE:

Non-covered/no exception

PRESSURE REDUCING SUPPORT SERVICES: CMN REQUIRED (SFN728). *Prior authorization required.*

Coverage allowed if the following conditions are present:

- Completely immobile, and
- The recipient cannot independently make changes in body position, and
- Pressure ulcer on the trunk or pelvis, and/or
- Impaired nutritional status, and/or
- Altered sensory perception, and/or
- Compromised circulatory status, and/or
- Incontinence of bowel or bladder.

Powered Pressure Reducing Mattress:

- Mattress overlay has failed, or
- Ulcers have worsened or remained the same over the past month, or
- Multiple stage II ulcers on the trunk or pelvis.

Air Fluidized Bed:

As an exception only.

- Without the bed, the patient would require institutionalization.
 - Stage III or IV ulcer.
 - Bed ridden as a result of severely limited mobility.
 - All other measures have failed.
 - Medical documentation needs to accompany the prior as well as the CMN to support the request.
 - Limited to 4 months rental.
- Foam overlay or mattress, which does not have a waterproof cover, is not considered DME and is non-covered/ no exceptions.

RESPIRATORY ASSIST DEVICES (BIPAP): CMN REQUIRED (form number to be posted).

Prior authorization required

Coverage allowed if the following conditions are present:

- Symptoms characteristic of sleep-associated hypoventilation, such as daytime hyper somnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.
 - Restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe chronic obstructive pulmonary disease, central sleep apnea or obstructive sleep apnea and the patient's oxygen saturation drops below 88% on room air.
 - Obstructive sleep apnea (OSA): AHI is greater than or equal to 15 events per hour, or the AHI is 5 to 15 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or Hypertension, ischemic heart disease, or history of stroke, and a single level device (E0601) has been tried and proven ineffective.
- An E0471 is not medically necessary if the primary diagnosis is OSA.
- Coverage will be allowed as rental for the first 3 months. If the patient is compliant and the therapy is effective, by review of the submitted documentation, purchase or continued rental will be allowed. Compliance is defined as 4 hours per 24-hour period by the time of re-evaluation.
- All supplies, other than a mask and headgear, are included during the rental period.

The following table represents the usual maximum amount of accessories expected to be medically necessary for use with patient owned equipment:

- | | |
|---------------------------------|---------------------------------|
| • <u>A7030</u> 1/6 months | • <u>A7034</u> 1/ 3months |
| • <u>A7031</u> 1/month | • <u>A7035</u> 1/6 months |
| • <u>A7032</u> 2/month | • <u>A7036</u> 1/6 months |
| • <u>A7033</u> 2/month | • <u>A7037</u> 1/month |

- A7038..... 2/month
- A7039..... 1/6 months
- A7046..... 1/6 months

A non-heated (E0561) or heated (E0562) humidifier is covered and paid separately for use with a covered E0470.

SADD LIGHTS: *Prior authorization required.*

Coverage allowed if the following conditions are present:

- Well-documented pattern of depressive episodes.
- Tabletop models only
- Diagnostic assessment from a Licensed Physician must have taken place
- If compliant and effective can submit for purchase after 3 months. Please submit medical documentation to support effectiveness.

SEAT LIFT MECHANISM: CMN REQUIRED (SFN #724). *Prior authorization required.*

- Coverage allowed if ALL of the following conditions are present:
- Prescribed to effect improvement or arrest or retard deterioration in the patients condition, and
- Completely incapable of standing up from a regular armchair or any chair in the home (e.g., severe arthritis of the hip or a neuromuscular disease), and
- Once standing has the ability to ambulate, and
- All other therapeutic modalities (medication, physical therapy) have been tried and failed.

Non-Covered: A seat lift mechanism (E0172) placed over or on top of a toilet, any type. No exceptions.

- The fact that a patient has difficulty, or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all patients who are capable of ambulation can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

SPEECH GENERATING DEVICE: CMN REQUIRED (*Number to be assigned*) *Prior authorization required.*

Coverage allowed if ALL of the following conditions are present:

- Prior to delivery of the speech generating device the patient has had a formal evaluation of their cognitive and language abilities by a speech-language pathologist, and
- A severe expressive speech disability is present.

The following information must be submitted for the Department's review to document the need for a device:

- A physician's prescription and CMN
- IEP
- Speech/language evaluation – no earlier than 6 months prior to submission
- Physician's statement or Therapists evaluation

- Other reimbursement resources

The professional services related to the communication systems, assessment, therapy, and follow-up monitoring services must be billed as speech-language therapy.

STANDING FRAME: *Non-covered/No-exceptions.*

SUCTION PUMPS: (E0600)

Coverage for patients who have difficulty raising and clearing secretions secondary to:

- Cancer or surgery of the throat or mouth
 - Dysfunction of the swallowing muscles
 - Unconsciousness or obtunded state
 - Tracheotomy
- Trach Suctioning: Allow up to 3 sterile catheters (A4624) per day.
 - Oropharynx Suctioning: Not sterile therefore catheters can be reused. Allow up to 3 catheters (A4624) per week.
 - Sterile Saline (A4216, A4217): Allowed for trach suctioning only. Sterile saline is not medically necessary for oropharynx suctioning.
 - Trach Care Kit: Includes gloves, cups, basin, and solutions. Allowed for trach suctioning only.
 - Included During Rental: Pump, battery, battery charger, carrying case, permanent collection bottles, and overflow valve.
 - Billed Separately: Disposable collecting bottles, connecting tubing, and suction catheters.
 - When billing for supplies greater than what is allowed, supporting documentation must accompany the prior authorization.

SURGICAL DRESSINGS:

Coverage allowed if the following conditions are present:

- Is medically necessary and ordered by a Licensed Physician, and
- Treatment of wounds post surgery, or
- Debridement of a wound.

Alginate/Fiber Dressings: (A6196-A6199)

- Allow one dressing per day.
- Allowed with highly exudative full thickness wounds.
- Non-covered for dry wounds or wound with Escher.

Composite Dressings: (A6200-A6205)

- Allow up to three dressings per week.
- Wound cover-one per dressing change.

Contact Layer: (A6206-A6208)

- Allow one dressing per week.

Foam dressings: (A6209-A6215)

- Allowed with full thickness wounds with moderate to heavy exudates.
- Allow up to three dressings per week.
- Allow filler once per day.

Gauze, Non-Impregnated: (A6216-A6221, A6402-A6404)

- Allow up to three times per day for a dressing without a border and once per day for a dressing with a border.

Gauze, impregnated, with other than water, normal saline, hydro gel, or zinc paste: (A6222-A6224, A6266)

- Allow up to once per day.

Gauze, impregnated, water or normal saline: (A6228-A6230)

- Non-covered/No exceptions

Hydrocolloid dressing: (A6234-A6241)

- Allowed for light to moderate exudates.
- Allow up to three times per week.

Hydrogel Dressing: (A6231-A6233, A6242-A6248)

- Allowed with full thickness wound with minimal or no exudates.
- Wound covers without borders-allow once per day.
- Wound covers with borders-allow up to three times per week.

Specialty Absorptive Dressing: (A6251-A6256)

- Allowed with moderate or highly exudative wound.
- Without borders-allow once daily.
- With borders-allow three times per week.

Transparent Film: (A6257-A6259)

- Allowed on open partial thickness wounds with minimal exudates or closed wounds.
- Allow up to three times per week.

Wound Filler: (A6261-A6262)

- Allow once per day

Wound Pouch: (A6154)

- Allow up to three times per week.

Tape: (A4450-A4452)

- Allow only to hold on a wound cover, elastic roll gauze or non-elastic roll gauze.
- Non-covered if ordered with border dressings.

Light, Moderate/High compression bandage, Self-adherent bandage, Conforming and Padding Bandage:

- Allowed to hold wound cover dressings in place.
- Allow no more than one per week unless used with a multi-layer compression bandage system.
- Allowed when they are part of a multi-layer compression bandage system used in the treatment of a venous stasis ulcer.

Silicone Gel Sheets: (A6025)

- Non-covered/ no exceptions.
- If the dressing has adhesive borders no additional tape is allowed.
- Dressing size must be based on, and appropriate to, the size of the wound.

- Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary and the reasons must be well documented.
- Suppliers are expected to have a mechanism for determining the quantity of dressings that the patient is actually using and to adjust their provisions of the dressings accordingly.
- No more than one-month's supply should be provided at a time.
- The physician order must specify the type of dressing, the size of the dressing, the number/amount to be used at one time, the frequency of dressing change and the expected duration of need. A new order will be needed if the type/quantity of dressing changes.
- All bandages when used for strains, sprains, edema, or situations other than as a dressing for a wound are non-covered.

THERAPEUTIC SHOES/ORTHOTICS:

Coverage allowed if any of the following conditions are present:

- Diabetic
 - Previous amputation of the other foot, or part of either foot
 - Peripheral neuropathy with evidence of callous formation of either foot
 - History of previous foot ulceration of either foot
 - Develop-mentally delayed
 - Congenital foot deformity
 - Individuals with braces attached to their shoe
 - Patients with severe foot deformities due to rheumatoid arthritis
- A podiatrist or physician knowledgeable in fitting of inserts or shoes must prescribe all shoes/inserts.
 - Flat Foot: Devices directed toward the care or correction of such conditions including the prescription of supportive devices is non-covered.
 - Custom Molded Shoe: Allowed only when the patient has a foot deformity that cannot be accommodated by a depth shoe. The nature and severity must be well documented in the supplier's records and must be made available when the department makes a request.
 - A modification of a custom molded or depth shoe will be covered as a substitute for an insert. Such modification would include such items as rigid rocker bottoms, roller bottoms, wedges, metatarsal bars or offset heels.
 - When a single shoe, insert or modification is provided, the appropriate modifier, right (RT), or left (LT), must be used.
 - Deluxe features (A5508): Non-covered/ no exceptions
 - High Top Shoes: Non-covered/ no exceptions
 - Inserts used in non-covered shoes will be non-covered/ no exceptions.
 - One additional pair of inserts with custom molded shoes and one pair of inserts with depth shoes.

Allowances:

Per Year: One pair of custom molded shoes/depth shoes

TLSO/LSO: (Prefabricated or custom fabricated)

Coverage if the following condition is/are present:

- If the device is necessary to help reduce pain by restricting mobility of the trunk, or
- To facilitate healing after surgery or injury to the spine, or
- Weakness of spinal/trunk muscles and/or a deformed spine.

Accessories:

- Protective body sock: Allow 2/year

TRACH CARE KITS: (A4625, A4629)

Coverage if any of the following conditions is/are present:

- Following an open surgical tracheotomy, which has been open or is expected to remain open for at least 3 months.
- Trach care kits provided in the first two postoperative weeks should be coded as A4625.
- Trach care kits provided after the first two postoperative weeks should be coded as A4629.
- One tracheotomy care kit per day allowed.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS): CMN REQUIRED (SFN 789).

Prior authorization required.

Coverage allowed if the following conditions are present:

- Chronic pain, or
- Intractable pain, or
- Acute postoperative pain.
- Other treatment modalities must have been tried and failed.
- If effective after the one month trial rental period the supplier can submit for purchase of the TENS unit and must provide documentation to support compliance and effective treatment.
- All supplies are included during the rental period and will not be reimbursed separately. Includes electrodes, lead wires, batteries, etc.
- Conductive paste or gel allowed if needed, and only with patient owned equipment only.

Supplies allowed after the purchase of the unit:

Electrodes: 2 units per month

Lead Wires: Only allowed for replacement if inoperable with max of one time per year.

UROLOGICAL SUPPLIES:

Coverage allowed if the following conditions are present:

- Permanent urinary incontinence, or

- Permanent urinary retention.
- Only when the catheter or the external urinary collection device meets the coverage criteria will the related supplies that are necessary for their effective use be covered.
- No more than one catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation substantiates medical necessity (e.g., catheter is accidentally removed, malfunction, obstruction).
- Leg bag (A4358 or A5112) are indicated for patients who are ambulatory or are chair or wheelchair bound. The use of both is not medically necessary.

WALKERS/GAIT TRAINERS:

Coverage allowed if ALL of the following conditions are present:

- Medical condition impairing ambulation, and
- There is potential for ambulation, and
- Need for greater stability and security.
- Heavy Duty: Allowed if patient weighs more than 300 lbs.
- Heavy Duty with Multi-breaking System: Allowed if severe neurological disorder or other condition causing the restricted use of one hand.
- Enhancement Accessories: Non-covered/ no exceptions.
- Pediatric gait trainer: Use appropriate code of E8000, E8001 or E8002.
- Adult gait trainers: Are billed using one of the codes for walkers. If a gait trainer has a feature described by one of the walker attachment codes that code may be separately billed. Other unique features of gait trainers are not separately payable and may not be billed with code E1399.

POWER WHEELCHAIR BASE: CMN (SFN720). *Prior authorization required.*

Coverage allowed if ALL of the following conditions are present:

- Would otherwise be confined to bed without it, and
- Unable to operate a manual wheelchair, and
- Capable of safely operating a power chair, and
- Severe weakness of the upper extremities.
- Options that allow the patient to perform leisure or recreational activities are non-covered/ no exceptions.
- One-month rental allowed if a patient-owned wheelchair is being repaired.
- Home assessment by a Licensed Physical Therapist must take place.
- Labor charges will be denied as included for any new wheelchair setups.

WHEELCHAIR OPTIONS/ACCESSORIES: CMN required (SFN720 or SFN781) *Prior authorization. required*

Coverage allowed if the following conditions are present:

- The patients condition is such that without the use of a wheelchair he/she would otherwise be bed or chair confined, and

- Options/Accessories are necessary for the patient to perform one or more of the following:
 - Function in the home
 - Perform ADL's

Leg Rests:

- Musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion of the knee, or
- Significant edema of the lower extremity that requires elevation, or
- Meets the criteria and has a reclining back on the wheelchair.
- Power elevating leg rests are non-covered.

Non-Standard Seat Frame:

- Only if the patients dimensions justify the need
- Batteries/Chargers
- Up to 2 batteries at a time if required for a power wheelchair
- Dual mode battery chargers are non-covered

Other Accessories:

- Electronic interface to allow a speech-generating device to be operated by the power wheelchair control interface.
- Anti-rollback device is allowed if the patient propels self and needs the device because of ramps.
- Safety belts/pelvic strap allowed if weak upper muscles, upper body instability or muscle, spasticity requiring this device for positioning.

Swing Away/Retractable/Removable Hardware:

- Required to perform a slide transfer to a chair or bed.

Reclining Back:

- Quadriplegia
- Fixed hip angle
- Trunk or lower extremity cast/braces that require reclining back feature
- Excess extensor tone of the trunk muscles
- Need to rest in a recumbent position 2-3 times during the day and transfer between chair and bed is difficult

Crutch/Cane Holder: Non-covered. Not medically necessary/ no exceptions.

Non-Standard Seat Frame:

- Can be billed separately if required seat width and/or depth of 20 inches or more for manual or power wheelchair.
- When submitting a prior auth for wheelchair repairs indicate when the chair was purchased.
- Repairs covered only for patient owned wheelchairs.
- K0108 – Include narrative description of the item being repaired/requested
- RP modifier must be used when prioritizing all repairs.
- RR or NU modifier required. If RR modifier is being used, please indicate the number of months being requested.

WHEELCHAIR SEATING: CMN: REQUIRED (SFN720 or SFN781). *Prior authorization required.*

The following seat cushion are allowed if:

- General seat cushion/general back cushion if:
 - Patient has a wheelchair
- Skin protection seat cushion if:
 - Current pressure ulcer or past history of, or
 - Absent or impaired sensation in the area that contact the seating surface, or
 - Inability to carry out functional weight shift.
- Positioning seat cushion/back cushion if:
 - Patient has significant postural asymmetry.
- Custom fabricated seat cushion/back cushion if:
 - Meets criteria for skin protection cushion or positioning cushion, and
 - Written evaluation which clearly explains why a prefab seating system is not sufficient to meet the patients seating and positioning needs.

WOUND THERAPY DEVICES: CMN REQUIRED (form number to be posted). *Prior authorization required.*

Coverage allowed if the following conditions are present:

- Chronic Stage pressure ulcer stage (III or IV), or
 - Neuropathic ulcer, or
 - Venous or arterial insufficiency ulcer, or
 - Chronic ulcers (present for at least 30 days).
- For all ulcers or wounds, the following components of a wound therapy program must include wound measurements/evaluation by a licensed medical professional, application of dressings to maintain a moist wound environment, debridement of necrotic tissue if present, appropriate measures taken regarding turning and positioning, moisture and incontinence have been appropriately addressed and diabetes has been appropriately managed.
 - Coverage ends when adequate wound healing has occurred to the degree that NPWT may be discontinued, any measurable degree of wound healing has failed to occur over the prior month, 4 months have elapsed using the NPWT pump in the treatment of the most recent wound (coverage beyond 4 months will be given individual consideration based upon required additional documentation), or once equipment or supplies are no longer being used for the patient, whether or not by the physician's order.
 - Wound therapy is non-covered if any of the following are present: Cancer in the wound, necrotic tissue present, fistula present or near the ulcer and any measurable degree of wound healing has failed to occur over the prior month.
 - Supplies, including dressings and canisters, are allowed under A6550 only and allowed up to 25 units per month.
 - Can only prior authorize one month at a time and allowed a maximum of 4 months rental (rolling months per calendar year).

PRIOR APPROVAL IS ALWAYS REQUIRED FOR THE FOLLOWING PRODUCTS

- Rental Equipment
- Miscellaneous codes
- Equipment or supplies at or above \$500
- Items purchased on a monthly basis that exceed \$500
- Estimated annual cumulative supplies or rental of \$500 or more
- Labor or repair charges of \$500 or more
- BIPAP
- CPAP
- TENS
- Lifelines
- Apnea Monitors
- SADD Lamps
- Hospital Beds
- Oxygen Equipment
- Wheelchairs
- Wound Vacs
- Speech Generating Device
- Pressure Reducing Support Services
- Parenteral/Enteral Nutrition
- Orthotics
- Osteogenic Stimulators
- Photo-therapy (Bilirubin Lights)
- Prosthetic Limbs and Supplies
- Hearing Aids
- External Infusion Pumps

LIST OF MODIFIERS

- | | | | |
|------|------------------------|------|----------------|
| – RR | Rental | – RT | Right Side |
| – NU | New Equipment | – UE | Used Equipment |
| – RP | Replacement and Repair | – LT | Left Side |

APPENDIX D – DME ALLOWED IN FACILITIES

LISTING OF ROUTINE DRUGS, SUPPLIES & DURABLE MEDICAL EQUIPMENT (DME) FOR SKILLED NURSING FACILITIES, ICF/MR, AND SWING BED FACILITIES

ITEMS TO BE SUPPLIED BY FACILITY, REFLECTED ON COST STATEMENT, AND NOT PAYABLE TO PHARMACIES OR OTHER SUPPLIERS

OVER-THE-COUNTER (NON-LEGEND) ITEMS, INCLUDING, BUT NOT LIMITED TO:

- Aspirin, Acetaminophen
- Antacids
- Antidiarrheals
- Antihistamines
- Hemorrhoidal Preparations
- Laxatives
- Liniments
- Lotions/Creams
- Vitamins

PERSONAL ITEMS, INCLUDING, BUT NOT LIMITED TO:

- Artificial Sweeteners
- Breath Fresheners
- Cleansing Antibacterial Solutions
- Denture Cream, Denture Adhesive
- Deodorant
- Mouthwash
- Razor Blades
- Salt Substitute
- Shampoos
- Soap
- Talcum Powder
- Tissues
- Toothpaste, Tooth powder, Toothbrush

SUPPLIES AND DURABLE MEDICAL EQUIPMENT (DME), INCLUDING, BUT NOT LIMITED TO:

- Ace Bandages
- Aerochamber/Inhalaid
- Alcohol (rubbing), Antiseptics, Hydrogen Peroxide

- Ambu Bags
- Apnea Monitors
- Band-Aids
- Bandages, including Ace bandages
- Batteries, Hearing Aid, Larynx
- Bedrails, Footboard
- BIPAP, CIPAP Machines
- Blood Glucose Monitoring Devices, test strips and supplies
- Blood Stool Testers
- Catheters, Tubing, Bags & Irrigating Syringes
- Communication Devices
- Clinistix, Ketostix, Dextrostix
- Clinitest, Diastix, Ketodiastix, etc.
- Commode Chairs
- Compression Stockings
- Cotton
- Cradles
- Crutches, Canes
- Deodorizers
- Dressings, Vigilon, Duoderm, Bioclusive
- Enemas, equipment and disposable
- Examination Equipment
- Finger Cots
- Fleece Pads, Sheep Skin
- Foam Pads
- Gastric Feeding Tubes, Sets, Bags
- Gauze, Gauze pads, 4 x 4's
- Geriatric Chairs
- Gloves
- Heating Pads
- Hot Water Bottles
- Humidifiers
- Ice Bags
- Incontinence Pads & Briefs, Underpads, Sanitary Napkins, Disposable
- Diapers
- IPPB Equipment
- IV Solutions Without Medication Admix
- IV Tray or Subcutaneous Tray and Tubing
- Lamps (SUN, SADD, psoriasis)
- Lubricants, e.g., Vaseline, K-Y Jelly
- Lymphoderma devices
- Needles, reusable and disposable (excluding Diabetic)
- Nebulizers
- Ostomy Supplies and Related Items

- Oxygen, Oxygen Masks, Oxygen Cannula, Oxygen Catheters, Oxygen
- Concentrators, Carts, Stands, Regulators, etc.
- Pumps, Parenteral and Enteral
- Q-Tips, Applicators
- Restraints
- Roho Cushions
- Seating Systems non-customized
- Sodium Chloride for Irrigation/Inhalation
- Specialized beds or mattresses costing less than \$25 per day
- Standing Frames
- Suction Machine and Supplies
- Supplemental Nutritional Formulas, e.g., Ensure, Infant Formula
- Suppositories, Glycerin
- Suture Trays
- Syringes, all types
- Tape, e.g., Micropore, Surgical
- T.E.D. Stockings
- Telfa
- Tes-Tape
- Thermometers
- Toilet Risers
- Tracheostomy Supplies
- Trapeze Bars
- Underpads
- Vaporizers
- Walkers
- Wheelchairs (ICF/MR excluded)

VACCINES FOR MASS IMMUNIZATIONS, INCLUDING, BUT NOT LIMITED TO:

- Influenza Vaccines
- Pneumonia Vaccines

ITEMS PROVIDED TO NURSING FACILITY RESIDENTS THAT WILL BE ALLOWED FOR SEPARATE PAYMENT TO DME SUPPLIERS

All items costing \$500 or more or with an estimated cumulative annual rental or combination cost of \$500 or more require prior approval.

- Hearing Aids
- Orthotics, shoes for diabetics, customized shoes, and custom seating systems for recipient owned equipment are allowed for separate payment, but must be ordered by a podiatrist and receive prior approval.
- Prosthetics, and must be ordered by a specialist and receive prior approval.
- Repair of recipient owned equipment for covered items – if cost of accumulative repair is less than purchase of a new item. (Patient owned before entering the nursing home)

- Specialized beds or mattresses costing \$25 or more per day
- Vacuum assisted wound closure system
- Ventilator

ITEMS PROVIDED TO ICF/MR RESIDENTS THAT WILL BE ALLOWED FOR SEPARATE PAYMENT TO DME SUPPLIERS

All items costing \$500 or more or with an estimated cumulative rental or combination costs of \$500 or more require prior approval and must be prescribed by a licensed provider.

- Communication devices
- Hearing Aids
- Orthotics, shoes for diabetics, customized shoes, and custom seating systems for recipient owned equipment are allowed for separate payment, but must be ordered by a podiatrist and receive prior approval.
- Other customized equipment determined to be medically necessary by prior authorization
- Oxygen concentrators and supplies
- Repair of recipient owned equipment – for covered items – not if accumulative repairs cost more than a new purchase
- Specialized beds or mattresses costing \$25 or more per day
- TENS
- Vacuum assisted wound closure systems
- Wheelchairs and accessories

ITEMS PROVIDED TO RECIPIENTS IN A SWING BED FACILITY THAT WILL BE ALLOWED FOR SEPARATE PAYMENT TO DME SUPPLIERS

All items costing \$500 or more or with an estimated cumulative rental or combination costs of \$500 or more require prior approval.

- Hearing Aids
- Orthotics, shoes for diabetics, customized shoes, and custom seating systems for recipient owned equipment are allowed for separate payment, but must be ordered by a podiatrist and receive prior approval.
- Prosthetics.
- Repair of recipient owned equipment for covered items—not if accumulative repairs cost more than a new purchase.
- Specialized beds or mattresses costing \$25 or more per day
- Vacuum assisted wound closure systems